(1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155322	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMP 08/12/2	LETED
	6050 S	CR 800 E 92		
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	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SCIDENTIFYING INFORMATION)  Recertification and arvey.  gust 8, 9, 10, 11, 12,  000215 155322 0267600  C	A. BUILDING B. WING  STREET. 6050 S FORT V  MUST BE PERCEDED BY FULL SCIDENTIFYING INFORMATION)  Recertification and arvey.  gust 8, 9, 10, 11, 12,  000215 155322 0267600  C	A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  NTEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECT EXCIT CORRECTIVE ACTION SHOULD CROSS REFERENCE TO A CITY OF THE CROSS REFERENCE	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  WIEMENT OF DEFICIENCIES OF MUST BE PERCEDED BY FULL SCIDENTIFYING INFORMATION)  FROUD PROPER PRADE TO THE APPROPRIATE  PROPER PROPERTY TAG  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PROPERTY TAG  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PROPERTY TAG  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  FOR CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ACT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: J81S11 Facility ID: 000215

TITLE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	A. BUILDING  B. WING	00	COMP 08/12/	LETED
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP CO CR 800 E 92 NAYNE, IN46814	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Quality review c Cathy Emswiller	ompleted 8/17/11 • RN				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	
		155322	B. WIN			08/12/2	011
	PROVIDER OR SUPPLIER		1	STREET A 6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814		
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TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0156 SS=B	The facility must in orally and in writing resident understand all rules and regular conduct and responsive facility. The faresident with the nudeveloped under sometification must be admission and durn Receipt of such inflamendments to it, writing.  The facility must in entitled to Medicaid time of admission when the resident Medicaid of the ite included in nursing State plan and for be charged; those that the facility offer resident may be or charges for those stresident when charand services speciand (B) of this second (B) of this second in the facility must in or at the time of action during the resident available in the facility in the facility in the facility is per die the facility in the facility in the facility is per die the facility must further faci	afform the resident both g in a language that the ends of his or her rights and actions governing resident ansibilities during the stay in cility must also provide the otice (if any) of the State (1919(e)(6) of the Act. Such the made prior to or upon fing the resident's stay. If formation, and any must be acknowledged in the state of the nursing facility or, becomes eligible for the made services that are gracility services under the which the resident may not other items and services ers and for which the harged, and the amount of services; and inform each neges are made to the items iffied in paragraphs (5)(i)(A) tion.  Inform each resident before, dimission, and periodically it's stay, of services for eduding any charges for eduding any charges for eduding any charges for each under Medicare or by the mate.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 08/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u></u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
RENAIS	SANCE VILLAGE			1	CR 800 E 92 VAYNE, IN46814		
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	procedures for es Medicaid, includin assessment unde determines the ex non-exempt resou institutionalization community spous resources which cavailable for payminstitutionalized spor her process of eligibility levels.  A posting of name telephone number advocacy groups and certification a office, the State oprotection and add Medicaid fraud contat the resident in State survey and concerning reside misappropriation of facility, and non-codirectives requirements specific finis chapter relapolicies and procedirectives. These provisions to information to all at the right to accept surgical treatment option, formulate a includes a written	arces at the time of and attributes to the e an equitable share of cannot be considered nent toward the cost of the couse's medical care in his spending down to Medicaid as, addresses, and as of all pertinent State client such as the State survey gency, the State licensure imbudsman program, the vocacy network, and the introl unit; and a statement may file a complaint with the certification agency in abuse, neglect, and of resident property in the compliance with the advance ments.  Somply with the cified in subpart I of part 489 ated to maintaining written adures regarding advance requirements include in and provide written adult residents concerning a or refuse medical or and, at the individual's an advance directive. This description of the facility's ent advance directives and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155322	B. WIN	G		08/12/2	011
	PROVIDER OR SUPPLIER		•	6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 WAYNE, IN46814		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	name, specialty, a physician respons  The facility must p facility written information residents and apply and written information and use Medicare how to receive refrozered by such because of acility failed to provide a regarding that two provided regarding non-coverage for reviewed who monotification of M (Resident #8, Resident #8, Residen	review and interview, the provide documentation to days notice was ang pending Medicare 3 of 3 residents et the criteria for redicare non-coverage. Sident #13, and Resident #13, and Resident #15 are Provider form for Resident #8. The edited the effective date of the esident's current Speech awas to end 2/17/11. The and dated by the zed representative on the general series in the estate of the esident's current speech awas to end 2/17/11. The and dated by the zed representative on the estate in the estate of the estate in the est	FO	0156	F156 CORRECTIVE ACTION FOR AFFECTED RESIDENTS Corrective actio cannot be accomplished for resident #8, #13 and #7 becathe "Notice of Medicare Prov Non-Coverage" letter had all been mailed. The date the residents were to receive the non-coverage notification hat passed prior to the facility receiving notice, via the surve process, that the letters lacked documentation of a phone conversation with the responsarty proving the 2 day notice. IDENTIFICATION/COLETIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS Residents admit to this facility who receive Medicare skilled services we have the potential to be affect Future "notice of Medicare provider non-coverage contadocumentation of phone con made with responsible party prove that there was indeed day notice of the non coverage. MEASURES FOR	ns ause ider eady eir d ey ed sible red tted uld cted. iins tacts to	08/29/2011

<b>l</b> i ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155322	B. WIN			08/12/20	11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
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	SANCE VILLAGE			FORTV	VAYNE, IN46814		
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IAG		· · · · · · · · · · · · · · · · · · ·	-	IAG	PREVENTIONNew non-cove	rago	DATE
		11:00 a.m., the Business			procedure for Medicare resid	٠ ١	
	' '	provided a "Notice of			will be implemented immedia		
		er Non-Coverage" form			Staff have been in-serviced		
		The form indicated that			the procedure on 8/29/11.Q/	<u> </u>	
		e of coverage of the			FOR PREVENTION The corrective actions are monitor	ored	
		Occupational Therapy			by the Business Office Mana		
	1 *	erapy services was to end			and the QA Committee will re	eview	
		form was signed and			monthly for one year. EFFEC		
	dated by the resid				<u>DATE</u> Compliance date is Au	gust	
		6/6/11, indicating the			29, 2011.		
	notice was receiv	ved on that date.					
	2 0 0/10/11	11.00					
		11:00 a.m., the Business					
		provided a "Notice of					
		er Non-Coverage" form					
		The form indicated that					
		of coverage of the					
		Speech Therapy services					
		11. The form was signed					
	· ·	resident's authorized					
	_	7/28/11, indicating the					
	notice was receiv	red on that date.					
		fice Manager was					
		/10/11 at 11:15 a.m.					
	~	riew, the Business Office					
	Manager indicate	ed if the representative					
		ilding, they are contacted					
		the services no longer					
	being covered to	inform them of the date					
	services would n	o longer be covered. The					
	Business Office I	Manager indicated she					
	contacted the rep	resentatives at least two					
	days prior to the	date of non-coverage by					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED A. BUILDING				ETED	
		155322	B. WING	-		08/12/2	011
	PROVIDER OR SUPPLIER		60	50 S	.ddress, city, state, zip code CR 800 E 92 VAYNE, IN46814		
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	indicated someting was documented Business Office In provide documer representatives be telephone to info non-coverage. The Manager indicated Resident #13 was 6/6/11, the day slow on 8/11/11 at 111 Office Manager Indicated Manager Indicated When the representatives who non-coverage. The method of non notified. The log of notice, the resistency including Physical Therapy and Speech Therapy a	Manager indicated the log he residents' vere notified of the he log did not indicate tification or who was gonly indicated the date ident's name, the type of high but not limited to, v, Occupational Therapy, apy, along with the ff person. The log resentative of Resident on 6/3/11 and the Resident #7 was notified log only went back to not include when the					

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	PROVIDER OR SUPPLIER			STREET A 6050 S	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814		
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TAG	An undated facil "Noncovered Le Business Office 11:00 a.m. The indicated the pol policy indicated (sic) a patient an and verbally noti responsible party liable for all char loosing (sic) thei with Medicare." indicated, "Not co to be issued, but contact the response offorts must be de If you are not ab party, you must of with the date and	ity policy entitled ters" was provided by the Manager on 8/11/11 at Business Office Manager icy was current. The "If the facility noncovers d does not issue the letter fy the beneficiary or y, the facility will be rges and runs the risk of r favorable waiver status The policy further only does the letter need the facility must also onsible party verbally. All ocumented on the letter. le to reach the responsible document your efforts I the time attempts are wo attempts should be		TAG	DEFICIENCY)		DATE
F0223 SS=D	verbal, sexual, ph	he right to be free from ysical, and mental abuse, ent, and involuntary					
	sexual, or physica	ot use verbal, mental, I abuse, corporal oluntary seclusion.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155322	B. WIN			08/12/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	CR 800 E 92		
RENAIS	SANCE VILLAGE				VAYNE, IN46814		
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(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
			F0	223	CORRECTIVE ACTION FOR		09/11/2011
	Based on intervi	ew and record review, the			AFFECTED RESIDENTS		
	facility failed to prevent verbal and				The alleged allegations from res #45 and #84 were investigated p		
	physical abuse o	f residents from staff.			facility policy at the time the all		
	1 ^ *	of 4 residents reviewed for			allegations occurred and reporte		
		ple of 14 who met the			the ISDH per state regulation.		
		•			staff members' involved (CNA		
	criteria for abuse	e. (Resident #45, and #84)			& #15) received disciplinary act		
					of termination after the investig		
	Findings include	:			was completed.		
	1. Review of the	clinical record of			IDENTIFICATION/CORRECTI	<u>VE</u>	
	Resident #45 on	8/10/11 at 10:43 a.m.,			ACTION FOR POTENTIALLY		
		lowing: diagnoses			<u>AFFECTED RESIDENTS</u>		
		re not limited to, anxiety,			Renaissance Village continues t		
	•	•			follow the facility policy "Abus		
		entia, and Alzheimer's			Prevention" to provide guidance	e on	
	type with depres	sion.			hiring employees. The policy requires an extensive criminal		
					background check, prior employ	700	
	Resident #45 wa	s interviewed on 8/9/11 at			reference check, validation of	yee	
	9:00 a.m. Durin	g the interview she			nursing aide register check, OIC	i list	
		s afraid of a particular			and sexual offenders list. The p		
		aused bruising to her			also incorporates guidance on	,	
		s while she was being			reporting and investigating		
		•			mistreatment, neglect, abuse, in	juries	
	1 -	bed bath. She indicated			of unknown origin and		
		abbed her arms when she			misappropriation of resident		
	was attempting t	o turn from side to side in			property. An in-service will be		
	her bed. She als	o indicated she showed			provided for all staff related to s	staff	
	the bruising to the	ne nurse but did not report			treatment to residents.		
	_	ne Administrator. She			MEACHDEC EAD DDEVENEYA	13.7	
		the CNA has a temper			MEASURES FOR PREVENTIO		
		she received a suspension			Renaissance Village continues t educate all new employees rega		
		_			the policy, "Staff Treatment to	iuiiig	
		t. The CNA has not taken			Resident" emphasizing the guid	eline	
		. Resident #45 could not			of NO TOLERENCE. Education		
	recall the name of	of the CNA.			continues upon hiring, annually		
	I		1		1 2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		A. BUII	A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  08/12/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814		
	SANCE VILLAGE  SUMMARY S (EACH DEFICIEN REGULATORY OR  Nurse's notes dat reviewed on 8/10 was no indication Resident #45 had bilateral arms.  Nursing admission 5/23/10, 7/9/10, did not indicate a arms.  LPN #3 was intered 2:50 p.m. During indicated Resider the skilled wing so since being on the indicated she had her bilateral force.  RN #8 was intered p.m. During the she had worked with the skilled on the second she lived on the second she worked with the skilled she worked	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ed 3/2/11 to 8/10/11 were 0/11 at 1:20 p.m. There in the nurse's notes If any bruising to her on assessments, dated 10/14/10, and 3/21/11, any bruising to bilateral rviewed on 8/10/11 at g the interview she int #45 had moved from to the 100 hall in 3/2011. The 100 hall, LPN #3 If not had any bruising to	B. WIN	STREET A	CR 800 E 92	t will  t will  t policy time.	(X5) COMPLETION DATE
	by Resident #45 8/10/11 at 10:10 could not locate a abuse involving to bilateral arms, bu						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	(X3) DATE SURVEY COMPLETED		
		155322	B. WING		08/12/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92	
RENAISS	SANCE VILLAGE		FORT V	VAYNE, IN46814	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	COMPLETION DATE
	#45 and CNA #1	4.			
	A facility investig dated 12/23/10, in been reported durof a resident by swere assisting CI #45, indicated Reand trying to hit at told Resident #45 her. CNA #14 la "I love it when sl #45 then yelled at to stop snapping when she did that continued to snapsuspended during terminated on 12  Nurse's notes for 12/23/10 at 5:00  Assistant Director informed the writes shift CNA was as a busive to Resides suspended until from Resident #45's plantified.  Nurse's notes for 12/24/10 at 12:10 adverse effects note	gation into alleged abuse, ndicated CNA #14 had e to alleged verbal abuse staff. Two CNA's who NA #14 with Resident esident #45 was yelling at CNA #14. CNA #14 to stop it and not to hit tughed, smiled and stated he's like this." Resident at CNA #14 and told her her gum, that she hated it t. CNA #14 laughed and to her gum. CNA #14 was gethe investigation and			

l í			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155322	B. WIN			08/12/2	.011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RENAISS	SANCE VILLAGE			1	CR 800 E 92 VAYNE, IN46814		
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(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		ng the interview she	+				
		ility dismissed CNA #14					
		•					
	due to her continuing tone of voice and attitude.						
ı	attitude.						
	2 Review of the	clinical record for					
		8/12/11 at 11:15 a.m.,					
		owing: diagnoses					
		re not limited to, severe					
	·	ymyalgia rheumatica,					
	and history of Be						
	unu motory or B	ms puis).					
	Nurse's notes for	Resident #84, dated					
		n., indicated Resident					
	•	(Resident #42) reported					
		told Resident #84 to take					
	off her blouse an	d pants, using a rough					
		#42 also indicated					
	Resident #84 can	not undress herself.					
	Nurse's notes for	Resident #84, dated					
	8/8/11 at 9:00 p.1	m., indicated the ADON					
	informed the wri	ter that Resident #42					
	stated CNA #15	told Resident #84 to put					
	her own clothes	on, in a rough voice.					
	Resident #84 was	s asked about the incident					
	but could not rec	all anyone being rough					
	with her. Reside	nt #42's stated "she					
	talked rough to y	ou last night." No					
	adverse effects w	vere noted from the					
	incident. Resider	nt #84 will continue to be					
	monitored. The	nurse's note also					
	indicated CNA#	15 was sent home					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
NAME OF F			_		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER	•		6050 S	CR 800 E 92		
	SANCE VILLAGE			FORT V	WAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
	pending further i	nvestigation.					
		Resident #84, dated					
	8/8/11 at 10:50 p	.m., indicated Resident					
	#84 could not rea	nember the incident with					
	the CNA. Reside	ent #42 stated "A CNA					
	was rough with h	ner et (and) told her to put					
	her own clothes	on." The nurse's note					
	also indicated the	ere were no adverse					
	effects noted to t	he resident from the					
	incident with the						
	Nurse's notes for	Resident #84, dated					
		n., indicated her POA					
	was notified of the						
	was notified of th	ie meident.					
	A minimum data	set (MDS) assessment					
	for Resident #84	, ,					
	l	erview of Mental Status					
		7/15, indicating severe					
	l ` ′	ment. The MDS also					
	1	nt #84 required extensive					
		•					
		ne physical assistance of					
	one staff for dres	sing.					
	A facility care mi	on for Posidont #94 with					
		an for Resident #84, with					
		of 8/11, indicated she					
		assistance with ADL's					
	l '	ily Living) due to severe					
	_	irsing interventions					
		re not limited to, assist					
	Resident #84 to dress daily.						
	A facility investi	gation into alleged abuse,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 08/12/2	ETED	
NAME OF 1	PROVIDER OR SUPPLIEI	<b>"</b> ?	'	1	ADDRESS, CITY, STATE, ZIP CODE		
RENAIS	SANCE VILLAGE				CR 800 E 92 VAYNE, IN46814		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	ndicated CNA #15 had					
	1	e of voice to Resident					
	1 ^	by her roommate Resident #42's had					
		that a CNA had told					
		take off her blouse and					
		tone of voice. Resident					
	1 .	ent #84 is unable to take					
	her own clothes	off. CNA #15 was					
	suspended durin	g the investigation and					
	terminated on 8/	11/11 for unprofessional					
	behaviors.						
	The MDC for Do	esident #42, dated 6/1/11,					
		S score of 15/15,					
		as cognitively intact.					
	marcating sile w	as cognitively intact.					
	The Administrat	or was interviewed on					
	8/12/11 at 11:15	a.m., during the					
	interview, the A	dministrator indicated the					
	facility had a zer	o tolerance policy for					
	abuse.						
	A assumant 1.1.	od facility maliary !! A large					
		ed facility policy "Abuse s provided by the					
		n 8/11/11 at 3:30 p.m.,					
		hall ensure, to the best of					
	I	esidents are free from					
	1	Verbal abuse: any use of					
		gestured language that					
		es disparaging and					
	1	s to residentsor within					
	heating distance	, regardless of their age,					
	ability to compre	ehend, or disability"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		155322	B. WING	10	<del></del>	08/12/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CR 800 E 92		
	SANCE VILLAGE				VAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE
	3.1-27(b)						
F0225 SS=D	have been found or mistreating resinave had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which was envice as a nurse the State nurse aid authorities.	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State v concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for a aide or other facility staff to de registry or licensing					
	violations involving abuse, including ir and misappropriat reported immediat the facility and to d with State law thro	ensure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are sely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the addrepresentative and accordance with State survey and dworking days of the	nvestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 to e incident, and if the alleged d appropriate corrective sen.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		155322	B. WING			08/12/2	011
NAME OF I	DROLUDED OR GUIDNI IED		ST	REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		60	)50 S C	CR 800 E 92		
	SANCE VILLAGE		FC	ORT W	/AYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	-	·		DATE
		ew and record review, the	F0225	)	CORRECTIVE ACTION FOR AFFECTED RESIDENTS		09/11/2011
		prevent verbal and			The alleged allegations from res	sident	
		f residents from staff.			#45 and #84 were investigated p		
	This affected 2 o	f 4 residents reviewed for			facility policy at the time the all	-	
	abuse in the sam	ple of 14 who met the			allegations occurred and reporte	ed to	
	criteria for abuse	. (Resident #45, and #84)			the ISDH per state regulation.		
					staff members' involved (CNA		
	Findings include	:			& #15) received disciplinary ac		
					of termination after the investig was completed.	ation	
	1 Review of the	clinical record of			was completed.		
		8/10/11 at 10:43 a.m.,			IDENTIFICATION/CORRECT	IVE	
		owing: diagnoses			ACTION FOR POTENTIALLY		
					AFFECTED RESIDENTS		
	· ·	re not limited to, anxiety,			Renaissance Village continues t		
	_	entia, and Alzheimer's			follow the facility policy "Abus		
	type with depress	sion.			Prevention" to provide guidance	e on	
					hiring employees. The policy		
	Resident #45 was	s interviewed on 8/9/11 at			requires an extensive criminal background check, prior employ	vee	
	9:00 a.m. During	g the interview she			reference check, validation of	yee	
	indicated she was	s afraid of a particular			nursing aide register check, OIC	G list,	
	CNA who had ca	used bruising to her			and sexual offenders list. The p		
	bilateral forearm	s while she was being			also incorporates guidance on		
		bed bath. She indicated			reporting and investigating		
	1	bbed her arms when she			mistreatment, neglect, abuse, in	juries	
		o turn from side to side in			of unknown origin and misappropriation of resident	l	
	1 .	o indicated she showed			property. An in-service will be		
		e nurse but did not report			provided for all staff related to		
		e Administrator. She			treatment to residents.	l	
						l	
		the CNA has a temper			MEASURES FOR PREVENTION		
		he received a suspension			Renaissance Village continues t		
		. The CNA has not taken			educate all new employees regathe policy, "Staff Treatment to	rding	
		Resident #45 could not			Resident" emphasizing the guid	leline	
	recall the name o	of the CNA.			of NO TOLERENCE. Education		
					continues upon hiring, annually		
	Nurse's notes dat	red 3/2/11 to 8/10/11 were					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
NAME OF	DD OLUDED OD GLIDDLIEF	`		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF			6050 S	CR 800 E 92		
	SANCE VILLAGE			<u> </u>	VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG			DATE
		0/11 at 1:20 p.m. There			on an as needed basis. Renaiss: Village continues to investigate		
	was no indication	n in the nurse's notes			allegations of abuse/neglect and		
	Resident #45 had	d any bruising to her			provide disciplinary actions as	1	
	bilateral arms.				deemed appropriate up to and		
					including termination.		
	Nursing admissi	on assessments, dated			<u>OA FOR PREVENTION</u>		
		10/14/10, and 3/21/11,			All allegations of abuse/neglect	will	
		any bruising to bilateral			continue to be investigated		
		any ordising to onateral			immediately by the departments	s	
	arms.				manager with appropriate		
					disciplinary measures enforced.		
		erviewed on 8/10/11 at			investigation will be placed on		
	2:50 p.m. Durin	g the interview she			spreadsheet by the DON or desi for review during the monthly	ignee	
	indicated Reside	nt #45 had moved from			QA&A meeting and		
	the skilled wing	to the 100 hall in 3/2011.			recommendations for potential	policy	
	Since being on the	he 100 hall, LPN #3			change will be directed at that t		
	_	d not had any bruising to					
	her bilateral fore				<u>EFFECTIVE DATE</u>		
	ner onaterar fore	(dilli).			The changes are completed and		
	DN #0 was inter	viewed on 8/10/11 at 2:53			effective by September 11, 201	1.	
	1 .	interview she indicated					
		with Resident #45 when					
		skilled wing. She also					
	indicated she co	uld not recall any bruising					
	to her bilateral a	rms.					
	Social Service #	16 was queried					
	concerning any a	allegation of abuse made					
	1 .	concerning staff on					
	1 *	a.m. She indicated she					
		any report of alleged					
		the bruising of her					
	_	_					
		ut provided an incident					
	1 -	23/10, between Resident					
	#45 and CNA #1	4.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 08/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u>                                     </u>			DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	SANCE VILLAGE			1	CR 800 E 92 VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	WITHE, III40014		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	dated 12/23/10, been reported du of a resident by swere assisting C #45, indicated R and trying to hit told Resident #4 her. CNA #14 la "I love it when s #45 then yelled at to stop snapping when she did that continued to sna suspended durin terminated on 12 Nurse's notes for 12/23/10 at 5:00 Assistant Direct the writer earlier CNA was accuse abusive to Resid suspended until Resident #45's p notified.  Nurse's notes for 12/24/10 at 12:1 adverse effects in The DON was in	gation into alleged abuse, indicated CNA #14 had be to alleged verbal abuse staff. Two CNA's who NA #14 with Resident esident #45 was yelling at CNA #14. CNA #14 5 to stop it and not to hit aughed, smiled and stated the's like this." Resident at CNA #14 and told her her gum, that she hated it at. CNA #14 laughed and p her gum. CNA #14 was go the investigation and 2/24/10.  The Resident #45, dated p.m., indicated the por Of Nursing informed in the day a 1st shift and of being verbally ent #45. The CNA was further investigation. The content in the day a stated of the investigation and shift end of being verbally ent #45. The CNA was further investigation. The content in the day a stated of the investigation and shift end of the investigation. The content investigation and shift end of the investigation and shift end of the investigation. The content investigation and shift end of the investigation and shift end of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J81S11

Facility ID:

000215

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MULTIPLE ( A. BUILDING B. WING	00	(X3) DATE COMP 08/12/2	LETED	
	PROVIDER OR SUPPLIER	2	6050	raddress, city, state, zip co S CR 800 E 92 WAYNE, IN46814	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
mo	indicated the fac	ility dismissed CNA #14 nuing tone of voice and	in to			Ditto
	Resident #84 on indicated the fol included, but we	clinical record for 8/12/11 at 11:15 a.m., lowing: diagnoses re not limited to, severe lymyalgia rheumatica, ells palsy.				
	8/8/11 at 3:39 p. #84's roommate told Resident #8 and pants, using	Resident #84, dated m., indicated Resident reported to writer a CNA 4 to take off her blouse a rough voice. The ndicated Resident #84 herself.				
	8/8/11 at 9:00 p. informed the writer Resident #84 staresident to put her rough voice. Reabout the incider anyone being rough #84's roommate to you last night were noted from #84 will continuinurse's note also	Resident #84, dated m., indicated the ADON iter the roommate of ted CNA #15 told the er own clothes on, in a sident #84 was asked at but could not recall agh with her. Resident stated "she talked rough." No adverse effects the incident. Resident e to be monitored. The indicated CNA #15 was ang further investigation.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MU A. BUIL B. WING	DING	NSTRUCTION  00	(X3) DATE COMPI 08/12/2	LETED	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	8/8/11 at 10:50 p #84 could not ret the CNA. The re stated "A CNA w (and) told her to The nurse's note no adverse effect from the inciden  Nurse's notes for 8/9/11 at 8:15 a.1 was notified of th  A Minimum Dat for Resident #84 indicated a Brief Status (BIMS) se severe cognitive also indicated Re extensive assista assistance of one  A facility care pl reviewed on 8/11 extensive assista (Activities of Da osteoporosis. No included, but we Resident #84 to of A facility investi	Resident #84, dated m., indicated her POA ne incident.  a Set (MDS) Assessment dated 5/5/11, Interview of Mental core of 7/15, indicating impairment. The MDS esident #84 required nee with the physical staff for dressing.  an for Resident #84, indicated she needs nee with ADL's ily Living) due to severe arsing interventions re not limited to, assist					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	COMPL 08/12/2	LETED
	PROVIDER OR SUPPLIER		•	6050 S	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	#84 as reported by Resident #84's reconcern that a C' to take off her bit tone of voice. Restated Resident # own clothes off. during the invest 8/11/11 for unprocess 11/11 for unprocess	d facility policy "Abuse vided by the a 8/11/11 at 3:30 p.m., facility shall ensure, to ility, that residents areabuseVerbal abuse: written, or gestured llfully includes derogatory terms to hin heating distance, ir age, ability to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155322 08/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6050 S CR 800 E 92 RENAISSANCE VILLAGE FORT WAYNE, IN46814 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1-28(e) The facility must provide housekeeping and F0253 maintenance services necessary to maintain SS=B a sanitary, orderly, and comfortable interior. 09/11/2011 F0253 F 253CORRECTIVE ACTION Based on observation, record review and FOR AFFECTED interview, the facility failed to ensure 1 of **RESIDENTS:**Carpet and 32 resident's rooms were free of urine bathroom floor cleaned in odor. (Resident #5) resident #5's room 8/22/11. Walls washed with a sanitizing solution. On 8/23/11 bathroom floor Finding includes: cleaned with enzyme cleaner. Bathroom continued to have urine On 8/10/11 at 11:05 a.m., Resident #5 was smell and was again cleaned with observed in her room, sleeping in a enzyme cleaner on 8/24/11. Bathroom floor sprayed with recliner. There was a strong odor of urine enzyme cleaner on 8/25/11. New coming from the resident and her chair. flooring ordered for bathroom.IDENTIFICATION/COR On 8/11/11 at 1:30 p.m., review of **RECTIVE ACTION FOR** resident #5's plan of care indicated the POTENTIALLY AFFECTED **RESIDENTS**Any room with a resident had occasional incontinence of strong urine smell will be reported bladder and a history of urinary tract to environmental infections. The resident also had a services. MEASURES FOR diagnosis of urge incontinence. **PREVENTION:**Environmental manager or designee weekly will tour facility to monitor for strong On 8/12/11 at 9:00 a.m., Resident #5 was smells. QA FOR observed in her room, seated in her **PREVENTION:**Environmental recliner. There was a strong odor of urine manager will monitor facility weekly for strong orders and present. environmental QA form for problem areas will be used to An interview was conducted with the track interventions which will be Housekeeping Supervisor on 8/12/11 at presented at monthly QA& A 10:25 a.m. During the Interview, she meetings. EFFECTIVE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	A. BUILDING B. WING	00 	COMPLETED  08/12/2011
	PROVIDER OR SUPPLIER		STREET 6050 S	ADDRESS, CITY, STATE, ZIP CODE S CR 800 E 92 WAYNE, IN46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
IAG	indicated Resider monthly and as mindicated the fact recliners.  On 8/12/11 at 10 Housekeeping Stranget was cleaned and she presented schedules. Revioleaning schedul cleaned on 6/24/been cleaned for Housekeeping Strange Resident #5's received.	nt #5's carpet was cleaned needed. She also fility cleans the resident's are as a sility clean the resident the apervisor indicated the end on a monthly basis, and the carpet cleaning are wo fresident #5's carpet are indicated it had been a sility for the apervisor also indicated aliner was new, and had yet. She also stated the	IAG	DATE: September 11, 2011 ADDENDUM Both mattresses were checthe room of resident #5. Be mattresses are intact. The mattresses were completel washed with sanitizing solutions.	cked in oth

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155322	B. WING			08/12/2	011
			D. WIII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			CR 800 E 92		
RENAISS	SANCE VILLAGE				/AYNE, IN46814		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280 SS=D	incompetent or oth incapacitated undo participate in plant changes in care a	care plan must be					
	of the comprehens by an interdisciplir attending physicia responsibility for the appropriate staff in by the resident's in practicable, the pathe resident's family representative; and revised by a team each assessment.						
	facility failed to of 2 residents (Reviewed for den 3 who met the cr 1 of 5 residents woutritional needs sample of 32 residential for nutritional for nutritio	: s record was reviewed on	FO	280	AFFECTED RESIDENTS The plan of care for resident # 17 #42 has been reviewed and revised to reflect the resident current status. IDENTIFICATION/COCTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS All residents' caplans regarding pressure are use of supplements or recensive in the potentially affected residents been reviewed and revised an needed. MEASURES FOR PREVENTION A review of Renaissance Village's care planning policy has been reviewed and no further charare recommended at this tim	e and it's or	09/11/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155322 08/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6050 S CR 800 E 92 RENAISSANCE VILLAGE FORT WAYNE, IN46814 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 5/11/11, indicated a problem/need which The Interdisciplinary team will gather weekly to review eight indicated Resident #17 was on a random care plans for 4 weeks therapeutic diet due to diabetes mellitus and then monthly to review eight and had no significant changes in weight, random care plans for six months. The Interdisciplinary had a good appetite, and had distinct food Team will continue to meet during preferences. The goal indicated the the MDS period of annuals, resident would consume 75-100% of quarterlies, and significant meals and snacks without significant changes to review plan of care changes in weight. There was no records. QA FOR PREVENTION All discrepancies found during the documentation on the care plan regarding review of records will be pressure areas, the use of supplements, or documented on a spreadsheet by recent weight loss. the Interdisciplinary Team, reviewed, and recommendation for potential policy changes made The dietary progress notes, dated 5/31/11, accordingly during the monthly indicated Resident #42 had distinct food QA&A meeting. EFFECTIVE preferences, and she was trying to watch DATEThe changes are completed her weight. The progress note also and effective by September 11, 2011. indicated the resident currently had a **ADDENDUM** wound to the left buttock, for which zinc All residents' care plans regarding and vitamin C had been started, and the dental needs will be reviewed for resident was refusing prosource (a accuracy by September 11, 2011. nutritional supplement), and indicated she couldn't get supplements past her nose. The dietary progress note indicated the current weight was 156 pounds, down 7 pounds (4.3%) from the previous month, over 3 months the weight was down 10 pounds (5.9%) and over 6 months, the resident's weight was down 22 pounds (12.4%). The note also indicated there was a risk for inadequate oral intake due to distinct food preferences, in planning her own menus and trying to lose weight,

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Event ID:

J81S11

Facility ID:

000215

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		A. BUI	LDING	00	COMPI 08/12/2	ETED	
		100022	B. WIN		DDDDGG GWW GWW GW GG	00,12,2	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	DDRESS, CITY, STATE, ZIP CODE  CR 800 E 92		
RENAIS	SANCE VILLAGE			1	VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		dent had been identified					
	as having protein	n mainutrition.					
	the Stage 2 press buttock continue the resident didn nutritional suppl Notes dated 7/30 Dietitian had sporegarding her for consequences of diet, and that the voice her desire	ements offered to her.  0/11, indicated the oken to Resident #42 od choices and not eating a balanced e resident had continued to for weight loss.					
	interview, the D	a.m. During the ietary Manager indicated visited recently. She					
		the resident would send					
		ary department every day					
		she would eat. The					
	resident had a pr	oblem with adequate					
	protein intake ar	nd did not like milk or					
	_	nt would eat cottage					
	cheese at times.						
	The "Nutritional	Care Plan" for Resident					
	#42 had not been	n updated to reflect these					
	_	esident's condition.					
		clinical record of					
		8/10/11 at 8:33 a.m.,					
		lowing: diagnoses					
	included, but we	ere not limited to,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
		1	D. 1711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			CR 800 E 92		
RENAIS	SANCE VILLAGE				VAYNE, IN46814		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	-	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	I .	gitation, depression with					
	psychotic feature	es and personality					
	disorder.						
	An admission as	ssessment for Resident					
	#17, dated 5/7/0	9, indicated she had upper					
	and lower dentu	• •					
	A current physic	eian's order for Resident					
	1	11, indicated she was to					
		nical soft diet with pureed					
		_					
	1	blems with chewing and					
	swallowing.						
	1	y assessment for Resident					
	#17, dated 9/28/	10, indicated a					
	mechanical soft	diet with puree meat was					
	the safest consis	tency for her due to					
	increased swallo	owing difficulty and slow					
		posterior) transfer of					
	solids.	posterior) transfer or					
	Joings.						
	A facility care of	lan for Resident #17, with					
	1 .	6/11, indicated she had					
		dentures but does not					
	1 **						
		daughter took them home,					
		anically altered diet, and					
		king episodes related to					
		no teeth) state. Nursing					
	interventions inc	cluded, but were not					
	limited to, monit	tor for increased chewing					
	and swallowing	problems.					
		-					
	A second facility	y care plan for Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	COM	TE SURVEY  IPLETED  1/2011	
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE			STREET 6050 \$	ADDRESS, CITY, STATE, ZIP C S CR 800 E 92 WAYNE, IN46814	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	#17, with a revie she required externation activities of daily Nursing interven not limited to, as complete oral carry upper and lower dentures every model time.  A third facility carry with a review datended to leave 2 uneaten at meals included, but we has upper and lower dentures but the daughter of a diet. The nurse's has dentures but the daughter of interviewed on 8 During the interviewe	w date of 6/11, indicated ensive to total assist for valiving (ADL) care. Itions included, but were sist Resident #17 to the twice daily; she has dentures, and apply forning and remove at the are plan for Resident #17, the of 6/11, indicated she 5% or more of her food. Nursing interventions are not limited to, teeth:				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155322	B. WIN			08/12/2011	
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
					CR 800 E 92		
RENAISS	SANCE VILLAGE			FORT V	WAYNE, IN46814		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X	5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CONTROL OF THE APPROPRIAT			
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DAT	Е
		et of dentures and they					
		erly. She also indicated					
		used to wear her dentures					
	and her daughter	took them home.					
	CDIA //C	. 1 0/10/11					
		erviewed on 8/10/11 at					
		ng the interview she					
		nt #17 refused to wear					
	her dentures.						
	The Director of N	Nursing (DON) was					
		/11/11 at 3:07 p.m.					
		view, she indicated care					
	_	wed during the weekly					
	-						
	_	gs. She also indicated					
	-	vas responsible for					
	updating their ca	re plans.					
	A current facility	care plan					
	_	", revised on October					
		A plan of care is to be					
	individualized to	-					
		changes in residents					
		an is to be updated"					
	need, the eare pro	an is to oc updated					
	3.1-35(d)(2)(B)						
F0282		ided or arranged by the				1	ļ
SS=D		ovided by qualified persons					
		n each resident's written					
	plan of care.						

NAME OF PROVIDER OR SUPPLIER  RENAISSANCE VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATEMENT OF DEFICIENCY FRONT, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  SUMMARY STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814  ID PROVIDER ACTOR STORE TO SHOULD BE CORSTRONTON SIDLE AND STORE	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  00			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  RENAISSANCE VILLAGE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREETADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREETADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREETADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREETADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92  FORT WAYNE, IN46814  SUBMINATOR OF STATE OF CORRECTION (X5)  COMPLETION DATE  PROVIDES PLANG CORRECTION (X5)  COMPLETION DATE  PREFIX  FO282  CORRECTIVE ACTION FIOR  AFFECTED RESIDENTS The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. JDENTIFICATION/COR	AND TEAN OF CORRECTION		A. BUI	LDING	<del></del>		
RENAISSANCE VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL RG ORDEATIVE ACTION FOOR LEACH CORRECTION (EACH CORRECTION DATE)  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  (X5) PROVIDERS PLAN OF CORRECTION (X5) (X5) (COMPLETION DATE  (COMPLETION DATE)  PREFIX (EACH CORRECTIVE ACTION FOR AFFECTED RESIDENTS) The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR		155522	B. WIN				011
RENAISSANCE VILLAGE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43)  reviewed for non-pressure related skin  ID  PROVIDERS PLAN OF CORRECTION  PREFIX  TAG  PREFIX  COMPLETION  DATE   COMPLETION  DATE   PROVIDERS PLAN OF CORRECTION  COMPLETION  DATE  COMPLETION  DATE  PROVIDERS PLAN OF CORRECTION  COMPLETION  DATE  O9/11/2011  F0282  CORRECTIVE ACTION FOR  AFFECTED RESIDENTS  The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR	NAME OF PROVIDER OR SUPPLIER						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY)  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  ID PROVIDERS PLAN OF CORRECTION PREFIX TAG (COMPLETION DATE  COMPLETION DATE  (X5)  COMPLETION DATE  O9/11/2011  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION FIOR AFFECTED RESIDENTS The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR	DENAISSANCE VILLAGE			1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  PREFIX (EACH DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SIOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDED (EACH CORRECTIVE ACTION SIOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE  COMPLETION DATE  COMPLETION DATE  PROVIDED (EACH CORRECTIVE ACTION SIOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION DATE  COMPLETION DATE  O9/11/2011  F0282  F0282  F0282  F0282  F0282  COMRECTIVE ACTION FOR AFFECTED RESIDENTS  The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR							
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Based on observation, record review and interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  AFFECTED RESIDENTS The plan of care for resident #12 has been reviewed and revised on the assignment sheet to include "do not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR	TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		
interview, the facility failed to follow the care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin			FO	)282	l ——		09/11/2011
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care plan to prevent accidents for 1 of 6 residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin	interview, the fac	cility failed to follow the			'		
residents reviewed (Resident #12) for accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin not leave alone in room while in wheelchair". The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR		•			1		
accidents who met the criteria. The facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin wheelchair. The plan of care for resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR	1 1				_		
facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  resident #43 has been reviewed and revised on the assignment sheet to include the turning and repositioning program.  IDENTIFICATION/COR		,			1		
facility further failed to re-position a resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin and revised on the assignment sheet to include the turning and repositioning program. IDENTIFICATION/COR					• · · · · · · · · · · · · · · · · · · ·		
resident in her wheelchair as care planned for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  sheet to include the turning and repositioning program. IDENTIFICATION/COR	1 *	•			1		
for 1 of 8 residents (Resident #43) reviewed for non-pressure related skin  reviewed for non-pressure related skin  reviewed for non-pressure related skin	resident in her w	heelchair as care planned			1		
I TOVICWOU TOT HOTE-DIOSSUIC TOTALOU SKIII	for 1 of 8 residen	nts (Resident #43)					
	reviewed for non	-pressure related skin				/COR	
conditions who met the criteria	I	•			<u>RECTIVE ACTION FOR</u>		
POTENTIALLY AFFECTED	Conditions who is	net the criteria.				_	
RESIDENTS All residents'	Finding sinch de					. 1 . 1 .	
Findings include:  assignment sheets are at risk to	Findings include	:					
be potentially affected. A review and revision, if necessary, of all					, ,		
1. On 8/11/11 at 10:00 a.m., Resident #12 assignment sheets will be	1. On 8/11/11 at	10:00 a.m., Resident #12				n all	
was observed sitting up in a comfort chair conducted. <u>MEASURES FOR</u>	was observed sitt	ting up in a comfort chair				OR	
in her room with a seat belt in place. The <u>PREVENTION</u> Any plan of care	in her room with	a seat belt in place. The			· · · · · · · · · · · · · · · · · · ·		
resident was alert with eyes open. No changes related to the CNA	<b>I</b>	_					
staff were present in the room scope of practice will be written	l l						
on a Plan of Change form to be	starr were present	to in the room.			, •		
utilized to update the assignment	The WEell Diele C	" d-t-d 7/25/11					
The "Fall Risk Screen," dated 7/25/11, sheet. A copy of the "Plan of	I						
indicated Resident #12 was at risk for Change" form will be directed to the DON or designee. Team		nt #12 was at risk for					
falls.  the bon or designee. Team  Leaders responsible for the	falls.						
update of the assignment sheet					•		
The "Falls" care plan for Resident #12, will be required to make updates	The "Falls" care	plan for Resident #12,					
dated 10/3/02 and reviewed 7/11, listed written immediately to the	dated 10/3/02 and	d reviewed 7/11, listed			•		
the nursing intervention of "Do not leave" assignment sheet with the typed		· ·					
alone in recompleted by	"						
Finday and copy given to the DON	arone in room wi	ion in chair.					
or designee for review of all		ALCA (AMDC)					
The Minimum Data Set (MDS)  assessment, dated 7/26/11, indicated  revisions. QA FOR  PREVENTION A log will be		, ,					
maintained by the DON or	I						
Resident #12 had both short and long designee indicating "Plan of	Resident #12 had	l both short and long				f	
term memory issues, inattention,  Change" forms submitted, and	term memory iss	ues, inattention,			, ,		
disorganized thinking and altered level of verification of changes made to	disorganized thir	iking and altered level of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CR 800 E 92		
RENAIS	SANCE VILLAGE			1	VAYNE, IN46814		
					77 (TTL), IT 100 TT		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	consciousness.				the assignment sheets. Any discrepancy from the "Plan or		
					Change" to the assignment s		
	The nurse's note	s, dated 7/30/11 at 3:45			will be reviewed monthly dur		
	p.m., indicated t	he writer was called to			the QA&A meeting for potential		
	Resident #12's re	oom by a CNA. The			revision of policy. <i>EFFECTIV</i>		
		served laying sideways on			<u>DATE</u> The changes are comp		
		. The resident was alert			and effective by September		
		writer. Stated "get me			2011. <u>ADDENDUM</u> A copy of "Plan of Change" form will al		
	up."	writer. Stated get me			distributed to the correspond		
	up.				hall for CNA's to sign. This	"'g	
	TI 1 1 CN				signature will serve as proof	of	
		A assignment sheet was			notification of the change.		
	1 ^	Director of Nursing on					
	8/10/11 at 3:40 p	o.m. The listing for					
	Resident #12 inc	licated she was a fall risk					
	but did not inclu	de the care plan					
	intervention of n	not leaving the resident					
		n while up in a chair.					
		<b></b>					
	An interview wa	as conducted with CNA #4					
		:15 a.m. During the					
		_					
	· ·	#4 indicated Resident #12					
	-	sometimes grabs things.					
		cated, the resident is					
	1 -	n her room but it was her					
	shower day and	Resident #12 was waiting					
	for her CNA to g	give her a shower,					
	During an interv	view with CNA #4 on					
	_	a.m., CNA #4 indicated					
		rovided to a resident can					
	_	CNA assignment sheet.					
	oc round on the	CIMI assignment sheet.					
	The Division C	Name in a (DON) and it is					
		Nursing (DON) provided					
	a copy of the ass	signment sheets for 300					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155322		(X2) MULTIPLE ( A. BUILDING B. WING	OONSTRUCTION  OO	(X3) DATE SURVEY COMPLETED 08/12/2011	
NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE			STREE 6050	F ADDRESS, CITY, STATE, ZIP CODE S CR 800 E 92 WAYNE, IN46814	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	indicated the info	t 10:30 a.m. The DON ormation, "do not leave nould be listed on the safety.			
	reviewed on 8/10 Diagnoses include to, Alzheimer's debullous (chronic involving the form of the served to prove the served to the served to prove the served to prove the served to the served to prove the served to the served to prove the served t	led, but were not limited ementia and pemphigus autoimmune skin disease mation of blisters).  30 p.m., staff were ide a treatment to attocks. The resident's served to be reddened ficial open areas. An right mid buttock was 5 cm (centimeters) by 1 ial depth. An open area buttock was 5 cm by 0.5 cm with An open area on the k was approximately 0.5 th superficial depth.  Ider monthly recap for Resident #43 had orders			
	and a goal date o	f 10/2011, indicated the k of a decline in skin			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMP: 08/12/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE	(X5) COMPLETION DATE
	integrity D/T (du Alzheimer's and Function. (Reside which causes operation) other areas of boother areas of	Decreased Level of ent #43) has pemphigus en lesions to buttocks and dy."  ed on the care plan re not limited to, turning g every two hours.  desident #43 for activities with a start date of oal date of 10/2011, ident "needs cuing at DLs (activities of daily eimer's and Decreased in."  ed on the care plan re not limited to, turning g approximately every in bed or in wheelchair.  Skin Assessment Tool dated 7/12/11, indicated bility was "very limited" make "occasional slight or extremity position but requent or significant dently."					
							1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLET	ΓED		
		155322	A. BUIL B. WING			08/12/201	11		
			B. WING		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	PROVIDER OR SUPPLIER	L.							
DENIAICO					CR 800 E 92 VAYNE, IN46814				
RENAISSANCE VILLAGE			FURIV	VATINE, IN40014					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORE			(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE		
	8:30 a.m. to 8:45	a.m.: Resident #43 was							
	sitting up in a wh	neelchair in the 100							
	hallway.								
	8:45 a m : unide	entified staff were							
		sport the resident from the							
		ain dining room for							
	breakfast.								
	8:45 a.m. until 9	:30 a.m.: Observed in the							
	main dining roor	n in a wheelchair eating							
	breakfast.	$\mathcal{E}$							
	or cannast.								
	9:30 a.m.: unide	atified staff were							
		sport the resident from the							
	_	n to the resident's room.							
	The staff position	ned the resident in front							
	of the television	and left the room.							
	During continual	l observations from 9:30							
	_	a.m., Resident #43 was							
		h her wheelchair in her							
		the television. No staff							
		enter the room during							
	the observation.								
	11:15 a.m.: Staff	were observed to enter							
	Resident #43's ro	oom and transport the							
		ain dining room. The							
		erved to reposition the							
		cived to reposition the							
	resident.								
	During continual	l observation from 11:15							
	a.m. until 12:00	p.m., Resident #43 was							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
		155322	A. BUILDING B. WING		08/12/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  CR 800 E 92	
RENAISSANCE VILLAGE			I	WAYNE, IN46814	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
		her wheelchair in the nin a group activity.			
		eserved to reposition the			
	resident during tl	ne observation.			
	CNA #11 was int	terviewed on 8/11/11 at			
	•	g the interview, CNA #11			
		dents in wheelchairs were			
	to be repositioned	d every two hours.			
		rviewed on 8/11/11 at			
	•	g the interview, LPN #3 dents in wheelchairs were			
		oned every two hours.			
	A facility policy	titled "Wound Care and			
		n a revised date of March			
	2011, indicated r	esidents were to be			
	repositioned appr hours when in ch	roximately every two			
	nours when in ch	ans of in oca.			
	3.1-35(g)(2)				
F0309 SS=D		st receive and the facility necessary care and services			
33-0	to attain or mainta	in the highest practicable			
		and psychosocial well-being, n the comprehensive			
	assessment and p	lan of care. ation, record review and	F0309	CORRECTIVE ACTION FOR	<u>R</u> 09/11/2011
		cility failed to re-position	1.0203	AFFECTED RESIDENTS Th	e
	a resident in her	wheelchair as care		plan of care for resident #12 been reviewed and revised of	I
				l	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155322		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPLI 08/12/20	ETED	
	PROVIDER OR SUPPLIER	<u> </u>		6050 S C	DRESS, CITY, STATE, ZIP CODE R 800 E 92 AYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	(X5) COMPLETION DATE
	planned for 1 of #43) reviewed for skin conditions of facility further far manner a new sk affected 1 of 7 rewise who met the critic in a sample of 32.  Findings includes 1. The record for reviewed on 8/10 Diagnoses included to, Alzheimer's of bullous (chronic involving the form of the served to prove Resident #43's buttocks were of with three superstopen area on the approximately 0 cm with superficial depth lower left buttock or by 0.5 cm with the superstopen area of the superstopen area of the superficial depth lower left buttock cm by 0.5 cm with super	8 residents (Resident or non-pressure related who met the criteria. The niled to assess in a timely in condition. This esidents (Resident #84) eria for skin conditions, 2.  The resident #43 was 0/11 at 1:00 p.m. ded, but were not limited dementia and pemphigus autoimmune skin disease mation of blisters).  80 p.m., staff were ide a treatment to uttocks. The resident's eserved to be reddened ficial open areas. An right mid buttock was 5 cm (centimeters) by 1 ial depth. An open area			assignment sheet to include not leave alone in room while wheelchair". The plan of carresident #43 has been review and revised on the assignment sheet to include the turning a repositioning program. IDENTIFICATION/OR RECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS All residents' assignment sheets are at risk be potentially affected. A revand revision, if necessary, of assignment sheets will be conducted. MEASURES FOR PREVENTION Any plan of conducted. MEASURES FOR PREVENTION are plan of Changes related to the CNA scope of practice will be writt on a "Plan of Change" form the utilized to update the assignment sheet. A copy of the "Plan of Change" form will be directed the DON or designee. Team Leaders responsible for the update of the assignment shewill be required to make updawritten immediately to the assignment sheet with the tyversion being completed by Friday and copy given to the or designee for review of all revisions. QA FOR PREVENTION A log will be maintained by the DON or designee indicating "Plan of Change" forms submitted, and verification of changes made the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets will be reviewed monthly during the reviewed monthly durin	e in e for ved ent and COR  k to view fall  DR are en o be ment f d to eet ates ped DON	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155322 08/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6050 S CR 800 E 92 RENAISSANCE VILLAGE FORT WAYNE, IN46814 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to "keep off bottom." the QA&A meeting for potential revision of policy. *EFFECTIVE* **DATE**The changes are completed A care plan for Resident #43 for skin and effective by September 11, integrity, with a start date of 11/17/2009 2011. ADDENDUM CORRECTIVE ACTION FOR and a goal date of 10/2011, indicated the AFFECTED RESIDENTS The resident "is at risk of a decline in skin plan of care for resident #43 has integrity D/T (due to) DX (diagnosis) been reviewed and revised on the Alzheimer's and Decreased Level of assignment sheet to include the Function. (Resident #43) has pemphigus turning and repositioning program provided by CNA's. An which causes open lesions to buttocks and immediate assessment and other areas of body." investigation was completed on resident #84 during the survey Interventions listed on the care plan process.IDENTIFICATION/CORR ECTIVE ACTION FOR included, but were not limited to, turning POTENTIALLY AFFECTED and repositioning every two hours. RESIDENTSAll residents' assignment sheets are at risk to A care plan for Resident #43 for activities be potentially affected. A review and revision, if necessary, of all of daily living, with a start date of assignment sheets will be 11/17/09 and a goal date of 10/2011, conducted. Nurses complete on indicated the resident "needs cuing at a weekly basis a form titled times with her ADLs (activities of daily "Weekly Summary". Part of the living) D/T Alzheimer's and Decreased "Weekly Summary" includes assessment of the resident's Level of Function." skin. Additionally, CNA's provide daily inspection of the skin as part Interventions listed on the care plan of their ADL care and report any new skin issue to the nurse for included, but were not limited to, turning follow-up. MEASURES FOR and repositioning approximately every PREVENTIONAny plan of care two hours when in bed or in wheelchair. changes related to the CNA scope of practice will be written A Braden's Scale Skin Assessment Tool on a "Plan of Change" form to be utilized to update the assignment for Resident #43, dated 7/12/11, indicated sheet. A copy of the "Plan of the resident's mobility was "very limited" Change" form will be directed to and was able to make "occasional slight the DON or designee. Team Leaders responsible for the changes in body or extremity position but

J81S11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155322		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED - 08/12/2011	
	PROVIDER OR SUPPLIEF	2	l	6050 S	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	unable to make fichanges independence on 8/11/11, the state observations were sitting up in a with hallway.  8:45 a.m.: Staff transport the resist the main dining some breakfast.  9:30 a.m.: Staff transport the resist of the main dining room breakfast.  9:30 a.m.: Staff transport the resist dining room to the staff positioned to the television and lessel of the observed to be in room in front of were observed to the observation.  11:15 a.m.: Staff Resident #43's room in front front #43's room in front fro	frequent or significant dently."  following continual re made:  6 a.m.: Resident #43 was neelchair in the 100  were observed to dent from the 100 hall to room for breakfast.  30 a.m.: Observed in the m in a wheelchair eating  were observed to dent from the main he resident's room. The che resident in front of the fit the room.  I observations from 9:30 a.m., Resident #43 was her wheelchair in her the television. No staff of enter the room during  If were observed to enter from and transport the		IAG	update of the assignment sh will be required to make upd written immediately to the assignment sheet with the ty version being completed by Friday and copy given to the or designee for review of all revisions. The DON or designial monitor four records week from the "24-Hour Report" for weeks, then 4 records month times five months with assessment of the resident of potential bruising after an inchas been reported. Any discovered discrepancies with addressed immediately. CN will be inserviced regarding updating of assignment sheet through the "Plan of Change form and nurses will be inseregarding timely assessmen skin. QA FOR PREVENTION log will be maintained by the or designee indicating "Plan Change" forms submitted, and verification of changes made the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" to the assignment sheets. Any discrepancy from the "Plan of Change" from the "Plan of Change" from the "Plan of Change" from the "Pla	ates  ped  DON  gnee ekly or four hly  cor cident  Il be A's  rviced t of VA  DON of hd e to  of sheet ing tial	DATE
	resident to the m	ain dining room. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	I	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP COI CR 800 E 92 NAYNE, IN46814	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	staff was not obs resident.	erved to reposition the				
	a.m. until 12:00 pobserved to be in main dining roor Staff were not obtained and the staff were not obtained at the staff were not obtained at the staff was interested at the staff was observed in purplish/blue brussize. One was observed in arm.	terviewed on 8/11/11 at g the interview, CNA #11 dents in wheelchairs were d every two hours.  rviewed on 8/11/11 at g the interview, LPN #3 dents in wheelchairs were ioned every two hours.  titled "Wound Care and h a revised date of March residents in were to be roximately every two hairs or bed.  12:00 p.m., Resident #84 her bed. Two hises, one centimeter in beserved on the resident's and one on the left upper				
	Resident #84's re	ecord was reviewed on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155322			(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 08/12	e survey pleted /2011
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP C CR 800 E 92 WAYNE, IN46814	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	_	o.m. There was no egarding any bruises on as.				
	p.m. During the indicated she wa on the resident's	viewed on 8/10/11 at 3:30 interview, RN #8 s unaware of the bruises arms, but if they had ocumentation would be in bk.				
	p.m. During the indicated she had	viewed on 8/10/11 at 3:38 interview, RN #8 d assessed the bruises on his and had measured the				
	interviewed on 8 regarding the bru arms. She indicated documentation of assessed in the refurther indicated completed and an indicated the residual indicated the residual regarding the regarding the residual regarding the regarding the residual regarding the residual regarding the residual regarding the regarding the residual regarding the regarding	rector of Nursing was /11/11 at 1:10 p.m., nises on Resident #84's ated there was no f the bruises being esident's record. She an assessment had been in investigation was being the bruising. She also ident was on medication the ease her risk of bruising.				

000215

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		A. BUILDING 00 COM 08/12		(X3) DATE S COMPL 08/12/2	ETED		
	PROVIDER OR SUPPLIER			6050 S	ddress, city, state, zip code CR 800 E 92 /AYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0315 SS=D	assessment, the faresident who enter indwelling cathete the resident's clinic that catheterization resident who is incompropriate treatmurinary tract infect normal bladder fur Based on observation interview, the fact proper catheter control to the catheter control to the catheter control to the catheter indicated by wiping front to back and perineal area and further failed to the provided by wiping front to back and perineum outward. Findings include the LPN #3 was interported by the indicated Resider catheter (indwell to a diagnosis of the record for R on 8/10/11 at 1:00 included, but we indicated, but we indicated, but we indicated the residence of the record for R on 8/10/11 at 1:00 included, but we indicated, but we indicated the residence of the record for R on 8/10/11 at 1:00 included, but we indicated the residence of the record for R on 8/10/11 at 1:00 included, but we indicated the residence of the record for R on 8/10/11 at 1:00 included, but we indicated the residence of the record for R on 8/10/11 at 1:00 included, but we indicated the residence of	ation, record review, and cility failed to provide are for 1 of 3 residents welling urinary catheters who met the criteria by eter tubing from the outward. The facility ensure perineal care was ng the resident from from the center of the d.	FO	315	CORRECTIVE ACTION FOR AFFECTED RESIDENTS Resident #43 has been observed is receiving appropriate catheter care/maintenance per facility po All nursing staff will be reeducathrough in-servicing and return demonstration regarding the pol for "Perineal Care" which include atheter care/maintenance.  IDENTIFICATION/CORRECTIACTION/FOR POTENTIALLY AFFECTED RESIDENTS All residents utilizing catheters the potential to be affected. All nursing staff will be reeducated through in-servicing and return demonstration regarding the pol for "Perineal Care" which include atheter care/maintenance.  MEASURES FOR PREVENTION The facility's policy for catheter has been reviewed and no changare indicated at this time. The nursing staff will be reeducated the policy related to catheter care with return demonstration required to continued education will be implemented to include as needs	icy des  WE  have  icy des	09/11/2011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION (X3) DATE S		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155322	B. WINC			08/12/2	011
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CR 800 E 92		
DENIAICO	SANCE VILLAGE				VAYNE, IN46814		
	SANCE VILLAGE			FORT	VATNE, IN40014		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The record indicate	ated the physician had			in-servicing for increased prese	nce of	
	diagnosed Reside	ent #43 with urinary tract			infection and continued return		
	infections and ha	d initiated antibiotic			demonstration bi-annually.		
	therapy on 5/23/	11, 6/13/11, 7/2/11, and			<u>OA FOR PREVENTION</u>		
	8/1/11.	,			Review of facility infections for	r I ITI	
	0/1/11.				will continue monthly. Each re		
	1 C D				will now have an "Infection Tra		
	•	Lesident #43 for urinary			Form" updated per the Infection	-	
	· ·	a start date of 11/17/09			Preventionist as infections occu		
	and a goal date o	f 10/2011, indicated the			Any repeat infection per resider	nt or	
	resident had a dia	agnosis of urinary			trending of infection identified	per	
	incontinence, uri	nary retention and had a			unit will be discussed at the mo	-	
		tract infections. The			QA&A meeting. Any revision		
		ed the resident was to			policy, reeducation or disciplina	ary	
	receive catheter				action will be discussed.		
	Tecerve cameter (	care twice dairy.					
					<u>EFFECTIVE DATE</u> The changes are completed and		
		00 a.m., CNA #2 was			effective by September 11, 201		
	•	ide perineal care and			effective by September 11, 201	1.	
	catheter care for	Resident #43 in her					
	room. CNA #2 v	vas observed to use a wet					
	wash cloth to cle	an the resident's perineal					
		as observed to wipe the					
		wash cloth, starting near					
		toward the perineal area.					
		•					
		n observed to clean the					
		nner thighs with a clean					
	wash cloth, wipii	ng from the inner thighs					
	towards the perir	neal area. CNA #2 was					
	then observed to	use a clean wash cloth to					
	clean the cathete	r tubing, wiping the					
	tubing toward the						
	Lacing to ward the	parinour urou.					
	CNIA #2 : : : : : :	erviewed on 8/11/11 at					
						ľ	
	-	roviding the care to					
	l Resident #43 D	uring the interview CNA	1				l

000215

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE S	ETED	
		155322	B. WIN	G		08/12/2	011
	PROVIDER OR SUPPLIER SANCE VILLAGE			6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 WAYNE, IN46814		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
IAU	#2 indicated that resident's perinea to be cleaned from outward and from further indicated to be cleaned by downward.  The Nurse Praction interviewed on 1 During the inte	during cleaning of a all area, the resident was me the perineal area a front to back. CNA #2 the catheter tubing was wiping from the meatus		inu			DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				CR 800 E 92		
RENAISS	SANCE VILLAGE				VAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE
F0323	<u>-</u>	nsure that the resident ins as free of accident					
SS=E		sible; and each resident					
		supervision and assistance					
	devices to prevent						
	Based on observa	ation, interview, and	F0	323	F323CORRECTIVE ACTION	-	08/12/2011
	record review, th	e facility failed to ensure			FOR AFFECTED		
	water temperatur	es in resident rooms on 1			RESIDENTS: Hot water was turned off 8/8/11 until plumbe	<sub>sr</sub>	
	of 3 halls were n	ot to hot and within the			could repair. Staff advised the		
	acceptable tempe	erature range for safety.			hot water could be obtained		
		er failed to monitor a			100 or 300 halls. Mixing valv	/e	
	_	tended in the resident's			repair completed and water		
		eted 1 of 6 residents (#12)			temperatures monitored by		
		idents in a sample of 32.			Maintenance supervisor and Plumber 1/2 hour before hot		
		•			water supplied to resident ro	oms	
	•	ential to affect 28 of the			Water temperatures then tak		
	28 residents on the	ne 200 hall.			resident rooms and found to		
					between 100-120°F. The pla	an of	
	Findings include	:			care for resident #12 has bee	en	
					reviewed and revised on the		
	1. On 8/8/11 at 3	3:42 p.m., water			assignment sheet to include		
	temperatures wer	e checked in resident			not leave alone in room while wheelchair".	# III	
	bathroom sinks o	on three halls of the			IDENTIFICATION/CORREC	TIVE_	
	facility with the	Environmental Director			ACTION FOR POTENTIALL	<u>Y</u>	
	and Maintenance				AFFECTED RESIDENTSWa	ter	
		. 1,1411			temperatures continue to be		
	The water tempe	rature in resident room			monitored daily with tempera		
	•				taken in 2 rooms on each ha different times of the day. Al		
		be 125.6 degrees F.			residents' assignment sheets		
	*	rature in resident room			at risk to be potentially affect		
	212 was noted to	be 127.4 degrees F.			A review and revision, if		
					necessary, of all assignment		
	Maintenance Ma	n #19 indicated the water			sheets will be conducted.		
	heater for the 200	) hall was located in the			MEASURES FOR		
		the 200 hall. The heater			PREVENTION: Water		
		om was observed and			temperatures continue to be	turos	
					monitored daily with tempera taken in 2 rooms on each ha		
	i reau at 107 degre	es, but as Maintenance	- 1		taken in ∠ 100ms on each na	ıı al	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155322	B. WIN			08/12/2	011
NAME OF I	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE		
DEMAIC				1	CR 800 E 92		
	SANCE VILLAGE			FORT	VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	•		DATE
		ading the heater gage, it			different times of the day. A plan of care changes related	•	
	was noted to go	from 107 degrees to 124			the CNA scope of practice w		
	degrees.				written on a "Plan of Change		
					form to be utilized to update		
	Maintenance Ma	nn #19 indicated there			assignment sheet. A copy o		
	must be a proble	m with the mixing valve.			"Plan of Change" form will be		
	At 4:26 p.m. on	8/8/11, Maintenance Man			direct to the DON or designe Team Leaders responsible for		
	#19 indicated he	had lowered the			update of the assignment sh		
	temperature on t	he mixing valve and was			will be required to make		
	_	temperatures down. He			immediate written updates to		
	, , , ,	ald monitor the water			assignment sheet with the ty	ped	
		ery 10 minutes until the			version being completed by Friday and copy given to the	DON	
	1 ^	ed. He indicated the			or designee for review of all	DON	
	1 *	res were checked on a			revisions.QA FOR		
	_				PREVENTION: Maintenance		
	1 .	resident rooms per hall,			Supervisor monitors water		
		ere rotated as well as the			temperatures on weekly che		
	time the checks	were completed.			sheets and reports any trend that will be presented at the	IS	
					monthly QA&A meeting. A lo	na will	
		0 p.m., the Administrator			be maintained by the DON of		
	was interviewed	. During the interview,			designee indicating "Plan of		
	the Administration	on indicated a plumber			Change" forms submitted, a		
	had been contact	ted and was coming today			verification of changes made		
	to fix the water h	neater. She indicated the			the assignment sheets. Any discrepancy from the "Plan of		
	hot water on the	200 hall was going to be			Change" to the assignment		
		problem was fixed.			will be reviewed monthly dur		
		r			the QA&A meeting for poten	tial	
	The undated "Ra	oster Sample Matrix" was			revision of policy. EFFECTIV	<u>E</u>	
		Administrator on 8/8/11			<b>DATE:</b> 8/12/11 for		
	1 ^	ne form listed 28 residents			environmental9/11/11 for nui <u>ADDENDUM</u>	sing	
	residing on the 2				CNA's will be inserviced		
	Tesiding on the 2	oo nan.			regarding Resident #12 plan	of	
					care.		
	1		1				1

000215

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	i .	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		6050 S	ADDRESS, CITY, STATE, ZIP C CR 800 E 92 VAYNE, IN46814	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	2. On 8/11/11 at was observed sit in her room with resident was aler staff were preser. The "Fall Risk S indicated Reside falls.  The "Falls" care dated 10/3/02 and the nursing internation alone in room with the minimum dated 7/26/11, in both short and local inattention, disonal tered level of company. The nurse's notes p.m., indicated the Resident #12's root resident was obsthe low bed matand grabbing at the low bed matand grabbing at the low of	10:00 a.m., Resident #12 ting up in a comfort chair a seat belt in place. The t with eyes open. No it in the room.  creen," dated 7/25/11, int #12 was at risk for  plan for Resident #12, d reviewed 7/11, listed wention of "Do not leave then in chair."  atta set (MDS) assessment, dicated Resident #12 had ing term memory issues, rganized thinking and				
	at fall risk but di	d not include the care				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	COM	TE SURVEY  IPLETED  2/2011
	PROVIDER OR SUPPLIER		6050 S	DDRESS, CITY, STATE, ZIP CO CR 800 E 92 VAYNE, IN46814	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	_	of not leaving the her room while up in a				
	on 8/11/11 at 10: interview, CNA gets into moods things. She furth is usually not left her shower day a waiting for her CD During an interv 8/11/11 at 10:45 care needs provide found on the CN The DON provide assignment sheet at 10:30 a.m. Thinformation, "do	s conducted with CNA #4 15 a.m. During the #4 indicated Resident #12 sometimes and grabs her indicated, the resident it in her room but it was and Resident #12 was CNA to give her a shower, hiew with CNA #4 on a.m., she indicated all hed to a resident can be A assignment sheet.  A assignment sheet  Is for 300 hall on 8/11/11 he DON indicated the not leave alone in room" on the care sheets under				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DDIG	00		COMPLETED	
		155322	A. BUILDING	-		08/12/2	011
			B. WING	ET ADDRES	S, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8	l l				
DENIAIC			•	0 S CR 80			
RENAIS	SANCE VILLAGE		FOF	KI WAYNE	E, IN46814		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EA CROS	ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0441 SS=F	Infection Control F a safe, sanitary ar and to help prever transmission of dis  (a) Infection Contr	establish and maintain an Program designed to provide and comfortable environment on the development and sease and infection.  Tol Program establish an Infection Control					
	Program under wh (1) Investigates, c infections in the fa (2) Decides what I isolation, should b resident; and (3) Maintains a rea	nich it - ontrols, and prevents					
	determines that a prevent the spread must isolate the re (2) The facility mu communicable dis lesions from direct their food, if direct disease.  (3) The facility mu hands after each of the spread o	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a sease or infected skin t contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
	transport linens so infection. Based on observ- interview the fac practiced proper cleaning of sciss	andle, store, process and of as to prevent the spread of ation, record review, and cility failed to ensure staff handwashing and ors while providing dressing change for 1 of 1	F0441	AFF Res for p cha	RRECTIVE ACTION FOR FECTED RESIDENTS sident #43 has been obse proper treatment and dresinge and is currently receing propriate care/maintenance	rved ssing ving	09/11/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: J81S11

Facility ID:

000215

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155322	B. WING		08/12/2011
NAME OF I	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•
TO HAVE OF I	NO VIDER OR GOLLEIER		6050	S CR 800 E 92	
	SANCE VILLAGE			T WAYNE, IN46814	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	NATE COM ELITOR
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
	`	nt #43) observed for		per facility's policy and prod for hand-washing and clear	
		essing changes) of 8		utilized equipment. All nurs	· 1
		ed who met the criteria		staff will be reeducated thro	
	1 -	related skin conditions.		in-servicing and return	
	The facility also	failed to ensure staff		demonstration for hand-wa	shing
	provided proper	catheter care for 1 of 1		and dressing changes. Additionally, resident #43 h	120
	residents (Reside	ent #43) observed for		been observed and is rece	
	catheter care of 3	residents reviewed who		proper catheter care/mainte	
	met the criteria for	or in-dwelling urinary		per facility policy. All nursi	ng staff
		icility further failed to		will be reeducated through	
		ticed proper handwashing		in-servicing and return	
	1 -	ministration of 2 of 3		demonstration regarding the policy for "Perineal Care" w	
	1	randomly observed.		includes catheter	THOT
	ı	failed to maintain an		care/maintenance. LPN #1	3 and
	I			RN #10 have been educate	ed for
	infection control			proper hand-washing after	
	_	nitored and analyzed		administering an insulin inju	
		data for the prevention		All nurses will be attending in-servicing and return	
		nfections. This had the		demonstration of hand-was	shina
	potential to affec	t 88 of 88 residents.		policies. Review of policies	· 1
				related to infection control	
	Findings include	:		isolation have been review	•
				updated to include individu	<u> </u>
	1. The record for	r Resident #43 was		for resident infection tracking differentiating the different	-
	reviewed on 8/10	0/11 at 1:00 p.m.		of isolation with direct expla	• •
	Diagnoses includ	led, but were not limited		of each type of isolation.	
	I -	ementia, pemphigus		IDENTIFICATION/CORRE	
	bullous (chronic	autoimmune skin disease		ACTION FOR POTENTIAL	•
	,	mation of blisters), and		AFFECTED RESIDENTS F residents receiving wound	
	urinary retention			with dressing changes, cat	•
				care, and those receiving	
	On 8/10/11 at 1:3	30 p.m., RN #1 was		medication after insulin inje	ctions
		ide a treatment and		have the potential for risk.	
	1 *	on the buttocks of		Additionally, all residents h	•
				potential for risk for recurre infection. All nursing staff v	
	Kesident #43. R	esident #43 was observed		incouon. An nuising stall t	viii be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDER OR SUPPLIER				CR 800 E 92		
RENAISS	ANCE VILLAGE			1	VAYNE, IN46814		
		TATEL ADATE OF DEDUCADA OF D		<u> </u>		1 (45)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA'	ΤE	DATE
IAG		·	+	IAG	reeducated through in-service	ina	DAIL
	_	g in bed on her left side.			and return demonstration for		
		ttocks were observed to			hand-washing in regards to		
	be reddened with	three superficial open			dressing changes and medic	ation	
	areas.				administration. All nursing s	taff	
					will be reeducated through		
	RN #1 was obser	ved to place her supplies,			in-servicing and return		
		s, directly on the overbed			demonstration regarding the policy for "Perineal Care" wh		
	-	aning the table first. RN			includes catheter	ICII	
		to put on exam gloves			care/maintenance. Continui		
	without first was	hing her hands. The			education will continue quart	-	
	nurse was observ	yed to clean the resident's			for hand-washing and cathet care until each staff member		
	buttocks with gar	uze and normal saline.			completed four successful re		
		l up the scissors from the			demonstrations. In-servicing		
	•	d used them to cut			be conducted to introduce	,	
					updated policies regarding		
	<del>-</del>	(petroleum covered			infection control tracking and		
	- '	isinfecting the scissors.			types of isolation with purpos	se for	
	-	laced small pieces of the			use. <u>MEASURES FOR</u>	- cc	
	-	pen areas on the resident's			<u>PREVENTION</u> All nursing sta will be reeducated through	an	
	buttocks. The nu	irse then placed the			in-servicing and return		
	scissors directly	onto the overbed table.			demonstration for hand-wash	ning	
	The resident ther	began to have a bowel			in regards to dressing chang	es	
		nurse removed the gloves			and medication administration	n.	
		esser in the room and			All nursing staff will be		
		f toilet paper. The nurse			reeducated through in-service	ing	
		hands after removing the			and return demonstration regarding the policy for "Peri	neal	
		e then put on a new pair			Care" which includes cathete		
	-	vithout first washing her			care/maintenance. Continui		
					education will continue quart		
	-	eded to use the toilet			for hand-washing and cathet		
		e resident's buttocks. The			care until each staff member completed four successful re		
		ted she had to get some			demonstrations. In-servicing		
	• •	The nurse was observed to			be conducted to introduce	,	
	<del>-</del>	es, gather her supplies			updated policies regarding		
	and leave the roo	m without washing her			infection control tracking and		
	hands. The nurse	e was observed to place			types of isolation with purpos	se for	

000215

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155322	B. WIN	IG		08/12/2	011
NAME OF	PROVIDER OR SUPPLIE	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CR 800 E 92		
RENAIS	SANCE VILLAGE			FORT V	VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 **	luding the scissors, into			use. <u>QA FOR PREVENTION</u> Logging of completed in-serv	_	
		he hallway and then left			by Staff Development will be		
	_	e supplies. Nurse #1 was			reviewed monthly during QA		
	then observed to	return to the medication			meeting to ensure all staff ar		
	cart, remove the	supplies and the scissors,			meeting the required educati		
	and enter Reside	ent #43's room. The nurse			Additionally, infection control		
	was observed to	again place the supplies			by the Infection Preventionis be reviewed and presented i		
	directly onto the	overbed table. The nurse			monthly QA&A meeting and		
	was observed to	put on a new pair of			written plans will be develope	ed, if	
	exam gloves wit	hout first washing her			necessary, to address any		
	1 -	se again cleaned the			identified infection control tre <u>EFFECTIVE DATE</u> The char		
	1	ks with gauze and normal			are completed and effective	-	
		e picked the scissors up			September 11, 2011.	~ <i>,</i>	
		ed table and cut the			<u>ADDENDUM</u>		
		without cleaning the			Care plans for residents with		
	1	rse then placed the small			infection/possible recurring		
		orm gauze directly onto			infections will be updated by Septmeber 11, 2011.	ted by	
	1 ~	n the resident's buttocks.			Geptilleder 11, 2011.		
	_	leted the treatment and					
	1						
	"	removed the gloves, and to wash her hands. The					
	1 *						
		ved to remove the					
	1	ng the scissors, from the					
		d take them out of the					
	1	em into the medication					
	cart.						
	Tri 1 . 1 #5	4 C 1 M 4 1 11					
		oster Sample Matrix",					
	1 "	Administrator on 8/8/11					
	1	sted 33 residents residing					
		above medication cart					
	contained ointme	ents and treatment					
	materials for the	33 residents residing on					
	the 100 hall who	were currently receiving					

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155322	A. BUII	LDING	00	08/12/20	
		100022	B. WIN			00/12/20	J11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  CR 800 E 92		
RENAISS	SANCE VILLAGE			1	VAYNE, IN46814		
					VATIVE, INTOOTT		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
0	treatments.						D.H.E
	treatments.						
	2 The record for	Resident #43 indicated					
		d diagnosed Resident #43					
		t infections, and had					
		ic therapy, on 5/23/11,					
	6/13/11, 7/2/11, a						
	0/13/11, //2/11, (	AII 0/ 1/ 11.					
	   On 8/11/11 at 8·6	00 a.m., CNA #2 was					
		ide perineal care and					
	•	Resident #43 in her					
		vas observed to use a wet					
		an the resident's perineal					
		as observed to wipe the					
		wash cloth, starting near					
		toward the perineal area.					
		n observed to clean the					
		nner thighs with a clean					
		ng from the inner thighs					
	-	neal area. CNA #2 was					
	•	use a clean wash cloth to					
		r tubing, wiping the					
	tubing toward the						
	doing toward the	e permear area.					
	CNA #2 was inte	erviewed on 8/11/11 at					
		roviding the care to					
	•	uring the interview, CNA					
		during cleaning of a					
		al area, the resident was					
	-	the perineal area outward					
		back. CNA #2 further					
		neter tubing was to be					
		g from the meatus					
	downward.	ig nom the meatus					
	uowiiwaiu.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	(X3) DATE COMP 08/12/2	LETED	
	PROVIDER OR SUPPLIER	<b></b>	605	EET ADDRESS, CITY, STA 50 S CR 800 E 92 RT WAYNE, IN4681		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE)	PLAN OF CORRECTION VE ACTION SHOULD BE JED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
	During the intervence would help reduct would help reduct #43 getting uring. A facility policy with a revision of indicated to clear were to "gently catheter from me further indicated to back and from thighs." The pol for females staff wash urethra are outside labia in a alternating from outward towards. The facility inferinterviewed on 8 During the interviewed on	1/12/11 at 10:45 a.m. view, the NP indicated care and perineal care ce the risk of Resident cary tract infections.  titled "Perineal Care, late of April 2011, n catheter tubing, staff wipe four inches of catus out" The policy "wipe resident from front n center of perineum to licy further indicated that were to "separate labia, a first. Wash between and downward strokes, side to side and moving				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155322		A. BUILDING B. WING	00	— COM 08/12	E SURVEY PLETED 7/2011		
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6050 S CR 800 E 92  FORT WAYNE, IN46814					
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE		
follow the facilit	y policy on providing						
indicated that alt responsible for the infections through not identified a curval was recurring used frequent use of a The facility's policated 2/2011, and 3/2011, did not a when putting on	hough she was ne surveillance of shout the facility, she had oncern with Resident rinary tract infections and ntibiotics. icies on hand washing, d wound care, dated ddress washing hands gloves or when removing						
observed admini injection to Residuates. After residuate the and water to clear proceeding to ad the next resident.  4. On 8/11/11 at observed adminisingection to Residuate administering the removed her gloven.	stering an insulin dent 87 while wearing moving her gloves, LPN unitizer rather than soap unse her hands before minister medication to 7:37 a.m., RN #10 was stering an insulin dent #107. After the injection, RN #10 wes and performed a four						
	SANCE VILLAGE  SUMMARY'S  (EACH DEFICIEN REGULATORY OR further indicated follow the facility catheter care and The infection con indicated that alt responsible for th infections throug not identified a c #43's recurring u frequent use of a  The facility's pol dated 2/2011, and 3/2011, did not a when putting on gloves during can  3. On 8/11/11 at observed adminis injection to Resid gloves. After rer #13 used hand sa and water to clea proceeding to ad the next resident.  4. On 8/11/11 at observed adminis injection to Resid and water to clea proceeding to ad the next resident.	OF CORRECTION IDENTIFICATION NUMBER:  155322 PROVIDER OR SUPPLIER	DENTIFICATION NUMBER:  155322  ROVIDER OR SUPPLIER  SANCE VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  further indicated staff are expected to follow the facility policy on providing catheter care and perineal care.  The infection control nurse further indicated that although she was responsible for the surveillance of infections throughout the facility, she had not identified a concern with Resident #43's recurring urinary tract infections and frequent use of antibiotics.  The facility's policies on hand washing, dated 2/2011, and wound care, dated 3/2011, did not address washing hands when putting on gloves or when removing gloves during care.  3. On 8/11/11 at 8:10 a.m., LPN #13 was observed administering an insulin injection to Resident 87 while wearing gloves. After removing her gloves, LPN #13 used hand sanitizer rather than soap and water to cleanse her hands before proceeding to administer medication to the next resident.  4. On 8/11/11 at 7:37 a.m., RN #10 was observed administering an insulin injection to Resident #107. After administering the injection, RN #10 removed her gloves and performed a four	OF CORRECTION 155322 SING 1553	OF CORRECTION  IDENTIFICATION NUMBER: 155322  ROUTGER OR SUPPLIER  SANCE VILLAGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Further indicated staff are expected to follow the facility policy on providing catheter care and perineal care.  The infection control nurse further indicated that although she was responsible for the surveillance of infections throughout the facility, she had not identified a concern with Resident #43's recurring urinary tract infections and frequent use of antibiotics.  The facility's policies on hand washing, dated 2/2011, and wound care, dated 3/2011, did not address washing hands when putting on gloves or when removing gloves during care.  3. On 8/11/11 at 8:10 a.m., LPN #13 was observed administering an insulin injection to Resident 87 while wearing gloves. After removing her gloves, LPN #13 used hand samitizer rather than soap and water to cleanse her hands before proceeding to administer medication to the next resident.  4. On 8/11/11 at 7:37 a.m., RN #10 was observed administering an insulin injection to Resident #107. After administering the injection, RN #10 removed her gloves and performed a four		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		155322	B. WIN			08/12/2	011
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					CR 800 E 92		
RENAIS	SANCE VILLAGE			FORT \	NAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
			F0	<b>1441</b>	CORRECTIVE ACTION FOR	<u> </u>	09/11/2011
	5. The Infection	Control Nurse was			AFFECTED RESIDENTS Resident #43 has been obse	rved	
	interviewed on 8	3/11/11 at 2:08 p.m.			for proper treatment and dre		
	During the interv	view, the Infection			change and is currently rece	•	
	Control Nurse in	dicated she had held this			appropriate care/maintenanc	-	
	position since 9/	20/11. She indicated if a			per facility's policy and proce		
	1 *	ced on an antibiotic for a			for hand-washing and cleani		
	_	ne nurse receiving the			utilized equipment. All nursi staff will be reeducated throu	•	
	•	ibiotic would fill out an			in-servicing and return	igri	
					demonstration for hand-wasl	ning	
		lance report form and			and dressing changes.	Ü	
	1 ^	fection control nurse's			Additionally, resident #43 ha		
	mailbox.				been observed and is received	-	
					proper catheter care/mainter		
	The Infection Co	ontrol Nurse indicated she			per facility policy. All nursing will be reeducated through	g stan	
	would get a copy	of the physician's order			in-servicing and return		
	and progress not	e, then log the			demonstration regarding the		
	information, incl	luding the resident's			policy for "Perineal Care" wh	ich	
	name, date order	red, type of infection,			includes catheter		
	organism involv	ed, and the antibiotic			care/maintenance. LPN #13		
	1 -	licated she logged in the			RN #10 have been educated proper hand-washing after	1 101	
	infections by hal				administering an insulin injec	ction.	
					All nurses will be attending		
	The Infection Co	ontrol Nurse indicated she			in-servicing and return		
		nservices on infection			demonstration of hand-wash	ing	
	1 *	ry tract infections,			policies. Review of policies related to infection control ar	nd	
					isolation have been reviewed		
	1 -	ks, proper peri care, and			updated to include individual		
	_	he indicated she did			for resident infection tracking	and	
		ations for handwashing,			differentiating the different ty	•	
	and pericare with	n the staff inserviced.			of isolation with direct explar	ation	
					of each type of isolation.  IDENTIFICATION/CORREC	TIVE	
		fection control inservices			ACTION FOR POTENTIALL		
	1	ed an inservice for			AFFECTED RESIDENTS All		
	urinary tract infe	ections was completed in			residents receiving wound ca	are	
	January, 2011, a	n inservice for wound			with dressing changes, cathe	eter	

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DINC	00	COMPL	ETED
		155322	B. WING			08/12/2	011
			p. white		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				CR 800 E 92		
RENAISS	SANCE VILLAGE				VAYNE, IN46814		
					7/(TVL, TV40014		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL	ŀ	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1	ted in March 2011, and			care, and those receiving	tions	
	an inservice for i	nfection control was			medication after insulin injec have the potential for risk.	lions	
	completed in July	y, 2011.			Additionally, all residents have	ve the	
					potential for risk for recurren		
	The Infection Co	ontrol Nurse indicated she			infection. All nursing staff wi		
		ped the CNAs on the			reeducated through in-service		
	floor, and if she	-			and return demonstration for		
	· · · · · · · · · · · · · · · · · · ·	•			hand-washing in regards to		
		e would talk to the			dressing changes and medic		
	· ·	t document this. She			administration. All nursing s will be reeducated through	laii	
		s planning on starting a			in-servicing and return		
		ent" with staff if she			demonstration regarding the		
	observed concern	ns with infection control			policy for "Perineal Care" wh		
	issues.				includes catheter		
					care/maintenance. Continui	-	
	The Infection Co	ontrol Nurse indicated if a			education will continue quart	•	
		ced on an antibiotic, a red			for hand-washing and cathet care until each staff member		
	_	placed by the resident's			completed four successful re		
		•			demonstrations. In-servicing		
		f the resident was on an			be conducted to introduce	,	
		is alerted housekeeping,			updated policies regarding		
	I -	sing staff that staff were			infection control tracking and		
	to see the nurse b	before entering the room.			types of isolation with purpos	se for	
					use. <u>MEASURES FOR</u>		
	She indicated no	ne of the residents were			PREVENTION All nursing sta	аπ	
	currently on any	kind of isolation			will be reeducated through in-servicing and return	l	
	1 '	e indicated the same red			demonstration for hand-wash	nina	
	l *	ed if a resident was on			in regards to dressing chang	•	
	-				and medication administration		
	isolation, as the c				All nursing staff will be		
		ndicated staff would			reeducated through in-service	ing	
	know a resident				and return demonstration		
	_	use a cabinet with gowns,			regarding the policy for "Peri Care" which includes cathete		
	gloves, and supp	lies for isolation would			care/maintenance. Continui		
	be placed outside	e the resident's room, and			education will continue quart		
	_	receive the information in			for hand-washing and cathet	-	
	report from the nurses				care until each staff member		

OF OF THE STATE OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPL 08/12/2	ETED
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6050 S CR 800 E 92				
ENAISSANCE VILLAGE  4) ID SUMMARY STATEMENT OF DEFICIENCIES LEFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			CR 800 E 92 VAYNE, IN46814  PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  completed four successful redemonstrations. In-servicing be conducted to introduce updated policies regarding infection control tracking and types of isolation with purpouse. QA FOR PREVENTION Logging of completed in-serby Staff Development will be reviewed monthly during QA meeting to ensure all staff at meeting the required educate Additionally, infection controby the Infection Preventionis be reviewed and presented monthly QA&A meeting and written plans will be develop necessary, to address any identified infection control tree.	eturn g will d see for Vicing e &A re ion. I logs at will in the	(X5) COMPLETION DATE	
control logs ever to the Administra Nursing Services control quarterly meetings.  The infection repand July 2011 we Infection Controresidents on the have urinary trace five residents on on the infections.  The infection condid not track records	e completed infection y month, and gave a copy ator and Director of the then discussed infection at the quality assurance  fort logs for June 2011 are reviewed with the l Nurse. In June, five l 00 hall were noted to to infections, and in July, the 100 hall were listed og as having urinary tract  attrol nurse indicated she arrent infections, but for oticed the same resident			EFFECTIVE DATE The char are completed and effective September 11, 2011.  ADDENDUM Care plans for residents with infection/possible recurring infections will be updated by Septmeber 11, 2011.	nges by	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322			ULTIPLE CO LDING	ONSTRUCTION  00	(X3) DATE ( COMPL 08/12/2	ETED	
		199322	B. WIN			06/12/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
RENAISS	SANCE VILLAGE			1	CR 800 E 92 VAYNE, IN46814		
		CTATEMENT OF DEFICIENCIES		<u> </u>	W/(INE, IIV+001+		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	names kept com	ing up on the infection					
	control logs, and						
		100 hall. She indicated					
	she planned on r	neeting with the Director					
	_	Assistant Director of					
	ı	omething together to track					
		She indicated she had not					
	done this in the	past. She indicated she					
	had logged the in	nfections and causative					
	agents, but had r	not been following up and					
	tracking why so	many urinary tract					
	infections were	occurring on the 100 hall.					
	The Environmer	ntal Director was					
	interviewed on 8	3/12/11 at 9:55 a.m.					
	During the inter-	view, she indicated there					
	were no resident	s on isolation at this time,					
	· ·	ent #107 had a dressing					
	_	were supposed to gown					
	I -	the dressing change. She					
		oinet with gowns and					
	l =	ed in the resident's room.					
		0:00 a.m., with the					
		Director and Maintenance					
		plastic cabinet was					
		dent #107's room, in a					
	_	to the right of the closet.					
		he cabinet were observed					
		masks, and gloves. The					
		Director indicated these					
		essing changes only, and					
	the resident was	not on isolation.					
	RN #6 was inter	viewed on 8/12/11 at					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		, ,	LDING	NSTRUCTION 00		(3) DATE S COMPL 08/12/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)		(X5) COMPLETION DATE
	REGULATORY OR  10:30 a.m. RN # #107 had surgery admitted to the fa methicillin resist aureus (MRSA) is was receiving va intravenously on indicated the resi facility with phys precautions. She was contained, as dressing and ace boot on her foot, change the dress indicated on 8/9/ doctor's appointer changed the dress nursing staff to s dressing. She indi the first dressing 8/10/11. She indi was ordered on a was using univer 8/9/11. She indi resident still rem isolation, but the ones in contact w wore gowns, glov indicated on 8/9/ placed the plastic room, which con and gloves. She	de indicated Resident on her ankle and was acility with a diagnosis of ant staphylococcus in the right ankle, and incomycin (an antibiotic) oce every night. She dent was admitted to the sician orders for contact of indicated the MRSA is the resident had a wrap and wore a special and nursing did not ing until 8/9/11. She 11, the resident had a ment, and the physician sing, then left orders for tart changing the dicated the resident had changed at the facility on icated contact isolation dmit, however, nursing sal precautions until cated after 8/9/11, the		I	CROSS-REFERENCE DEFIC	D TO THE APPROPRIATE CIENCY)		
FORM CMS-2	the MRSA was c	ontained in the dressing.  ns Obsolete Event ID:	J81S11	Facility I	D: 000215	If continuation shee	et Pa	ge 59 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155322			LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	During the intervious logging the the causative org investigating to disservicing for stindicated the fact specific isolation isolation, or MR MRSA, but the function was one of MRSA, she would gowns to be work indicated she was a she had infection surveil nurse. She indicated she was reviewed with Nurse at 1:30 p.1 indicated she had from RN #6. She made the form of admitted to the form of admitted to the form of was dated 8/1/11	/12/11 at 1:15 p.m. view, she indicated she infections monthly, with ganisms, but not determine if follow-up or raff was needed. She ility did not have a a policy for contact SA, except for respiratory racility used the utions. She indicated if a contact isolation for ld expect gloves and in with care. She is not aware Resident stact precautions for d not received an lance form from the ated normally gowns and placed in a dresser						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	li i	E SURVEY PLETED (2011
	PROVIDER OR SUPPLIER	2	6050 S	address, city, state, zip co CR 800 E 92 VAYNE, IN46814	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	1	weeks due to MRSA in The form also indicated to be on contact				
	reviewed on 8/12 Physician orders contact precautic record review, the indicating the rescontact precautic Set (MDS) Asses interviewed on 8 During the care precautic this on t	dated 8/1/11, indicated ons. At the time of the here were no care plans sident was to be on ons. The Minimum Data assment Nurse, was 8/12/11 at 1:55 p.m. view she indicated she he resident was to be on ons so did not indicate				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	CR 800 E 92		
RENAISS	SANCE VILLAGE			l	WAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	room. 3.1-18(b)(1)						
	3.1-18(j)						
	3.1-18(1)						
F0465	The facility must n	rovide a safe, functional,					
F0465 SS=D	sanitary, and comf	fortable environment for d the public.	F.0	465	FACE CORRECTIVE ACTION	•	00/11/2011
		ation, record review and	F0	465	F465 CORRECTIVE ACTION FOR AFFECTED RESIDENT	_	09/11/2011
		cility failed to ensure 1 of			Refrigerator located in medic		
	_	1 of 1 medication			room cleaned 8/10/11.		
	storage rooms we	ere clean and without			IDENTIFICATION/CORRECT	IVE	
	spillage.				ACTION FOR POTENTIALLY	<u>′</u>	
	Findings include	:			AFFECTED RESIDENTS Refrigerator will be monitored daily for spills and cleaned as needed. MEASURES FOR		
	During an observ	vation of the medication			PREVENTION: Housekeepe	r will	
	storage room wit	th the Director of Nursing			check daily and clean any sp		
	on 8/10/11 at 1:0	0 p.m., the following was			med room refrigerator. QA F		
	observed: a full	refrigerator containing			PREVENTION: Environment		
	pitchers of juice.	applesauce and pudding.			manager will monitor on a we basis for 3 months and repor	-	
	_	sticky substance was			concern to QA committee	t arry	
		ng the bottom shelf in the			EFFECTIVE DATE: Septemb	er	
		down into the bottom			11, 2011		
	drawers.	action and contoni					
	arawors.						
	An interview was	s conducted with the					
		ing on 8/10/11 at 1:14					
		interview, after making a					
		keeping Supervisor, the					
	Director of Nursi	1 0 1					
	Director of Mulsi	ing mulcateu	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION  00	` ′	E SURVEY PLETED	
THINDTEMIN	or connection	155322	A. BUILDING		08/12/	
			B. WING STRE	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		605	0 S CR 800 E 92		
RENAISS	SANCE VILLAGE		FOF	RT WAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
		eans the refrigerator				
	"Cleaning Med R provided by the I on 8/10/11 at 2:2 the following: ". environment and spread of infection	y and procedure for doom," dated 6/9/10, was Housekeeping Supervisor 3 p.m. The policy listed to maintain a clean thereby prevent the onBi-weeklyclean bactericidal solution and				
F0514 SS=D	each resident in according professional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services proving preadmission screed state; and progress Based on recording facility failed to educumentation of	review and interview, the ensure accurate f medication refills for 1 eviewed for medication	F0514	CORRECTIVE ACTION AFFECTED RESIDENT: The pharmacy has been cand updated with the corrinformation for resident #	ontacted rect dosing #20.	09/11/2011
	Findings include:			ACTION FOR POTENTI		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	
		155322	B. WIN			08/12/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DENIAIO	241051/11405			1	CR 800 E 92		
RENAIS	SANCE VILLAGE			FORTV	VAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	E CO	OMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	the Assistant Directorder indicated Receive oxybutyre daily.  The "Routine Med 2011, indicated Freceiving oxybut A "New Prescrip 8/4/11 from the proder for oxybuty."	ractive bladder ed 8/3/11, was signed by ector of Nursing. The desident #20 was to ain 5mg (milligrams)  eds" sheet, dated August Resident #20 was ynin 5mg twice daily.  tion Request" form, dated bharmacy, indicated an ynin 5mg daily.			AFFECTED RESIDENTS  All residents who have outside pharmacy or those being discha with handwritten prescriptions I the potential for risk. All prescriptions generated by the DON/ADON will be logged and double checked for accuracy.  MEASURES FOR PREVENTION  All prescriptions generated by the DON/ADON will be logged and double checked for accuracy by another staff member.  QA FOR PREVENTION  The log will be monitored by the DON or designee every time and prescription is written and prescription is writt	inave  in the control of the control	
	Director of Nursi 9:30 a.m. During indicated the pred by the Assistant I (ADON) and sen refilling the medi not been refilled indicated a pharm to be sent to the p	pharmacy since the Id be listed for twice			EFFECTIVE DATE The changes are completed and effective by September 11, 201		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
			D. (112)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6050 S	CR 800 E 92		
	SANCE VILLAGE				WAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0518 SS=D	emergency proced work in the facility:	rain all employees in dures when they begin to geriodically review the xisting staff; and carry out f drills using those					
	Based on intervie	ew and record review, the	F0	518	F518 CORRECTIVE ACTION	_	09/11/2011
	facility failed to	ensure 1 of 3 staff			FOR AFFECTED RESIDENTS		
	interviewed for e	mergency procedures			Employees working in laundr be in-serviced on facility's fire		
	was knowledgeal	ble of the facility's fire			procedure plan and be able t		
	procedure plan.	(Employee #18)			demonstrate verbal knowled		
		,			IDENTIFICATION/CORRECT		
	Findings include	:			ACTION FOR POTENTIALLY AFFECTED RESIDENTS All	_	
	1 Employee #19	8 was interviewed on			resident have the potential to		
		.m., with Maintenance			affected. Staff training will be completed. MEASURES FOR		
	•	-			PREVENTION: Laundry	<u> </u>	
		Environmental Director.			employees will receive training	ng	
		dicated if there was a fire			upon hire and yearly specific		
	•	e laundry room, the			laundry department regarding	9	
		try to extinguish the fire			facility fire procedure plan.		
	then go to the nu	rse's station to report the			Emergency gas shut off procedure posted in laundry	oroo	
	fire.				for quick referral. <b>QA FOR</b>	area	
	Review of the un	dated policy for fire			PREVENTION Training upon and yearly including specific	hire	
	procedures, prov	ided by Maintenance			laundry and gas shut off in ca		
	Man #19 on 8/12	/11, did not cover			of emergency. Environmenta		
	procedures for fi	res in the laundry room,			Manager to observe annual q shut off return demonstration		
	•	y provided by the			laundry employees and repo	•	
	Environmental D	, ,			results and recommendation		
		t off procedure laundry,"			QA&A committee. EFFECTI	<u>/E</u>	
		In the event of an			DATE September 11, 2011		
	emergency the main gas shut off is outside						
at the end of the north hall. An adjustable wrench is hanging outside at the shut off							
	vaive. Place wre	ench on valve and turn 1/4	- 1		I		l

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY  COMPLETED  08/12/2011
	PROVIDER OR SUPPLIER		STREET A 6050 S	ADDRESS, CITY, STATE, ZIP CODE CR 800 E 92 WAYNE, IN46814	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	8/12/11 for Empl employee had be	kwise."  cility orientation on loyee #18, indicated the en orientated to disaster rocedures on 1/24/11.			
F0520 SS=F	and assurance condirector of nursing designated by the members of the father than the quality assess committee meets a issues with respect assessment and an ecessary; and deappropriate plans identified quality described as a state compliance of the compliance of requirements of the Good faith attempidentify and correct be used as a basis Based on observers.	sment and assurance at least quarterly to identify but to which quality assurance activities are evelops and implements of action to correct efficiencies.  Cretary may not require ecords of such committee such disclosure is related to such committee with the is section.  Its by the committee to at quality deficiencies will not as for sanctions.  Factor, record review, and cility failed to ensure the	F0520	CORRECTIVE ACTION FOR AFFECTED RESIDENTS of meetings will continue more per facility policy with the results.	QA&A nthly as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R			CR 800 E 92		
RENAIS	SANCE VILLAGE			1	VAYNE, IN46814		
				<u> </u>	V/ (114E, 11440014		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION)	-	TAG		.14 4	DATE
	1	mmittee identified			director and pharmacy consu attending quarterly. The QA		
	potential infecti	on control concerns. This			meeting will include the logg		
	had the potential	l to affect 88 of 88			infections by individual resid		
	residents residin	g in the facility.			and potential concerns relate		
					recurrent infections. Prior po		
	Findings include	··			will continue to be followed in	n	
					tracking of		
	1 The Infection	Control Nurse was			infections. <u>IDENTIFICATION</u>	<u>//CO</u>	
					RRECTIVE ACTION FOR		
		3/11/11 at 2:08 p.m.			<u>POTENTIALLY AFFECTED</u> <u>RESIDENTS</u> All residents ha	)\/O	
		view, she indicated if a			the potential to be at risk. The		
	resident was pla	ced on an antibiotic for a			QA&A meeting will include the		
	new infection, th	ne nurse receiving the			logging of infections by indiv		
	order for the ant	ibiotic would fill out an			resident and potential conce		
	infection surveil	lance report form and			related to recurrent infection:		
		fection Control Nurse's			Prior policies will continue to	be	
	mailbox.	Total Comment (Masses			followed in tracking of	,	
	manoox.				infections. <u>MEASURES FOF</u> <u>PREVENTION</u> QA&A meetir		
	The Infection C	(1NI			will continue monthly as per	iys	
		ontrol Nurse indicated she			facility policy with the medica	al	
	1	y of the physician's order			director and pharmacy const		
	and progress not	<del>-</del>			attending quarterly. The QA	&A	
	information, inc	luding the resident's			meeting will include the logg		
	name, date order	red, type of infection,			infections by individual resid		
	organism involv	ed, and the antibiotic			and potential concerns relate		
	"	dicated she logged in the			recurrent infections. Prior po will continue to be followed in		
	infections by ha				tracking of infections. QA FC		
	inicetions by na				PREVENTION During the Q		
	The infection re-	port logg for June 2011			meeting, minutes and plan o		
	1	port logs for June 2011			action, if necessary, will be v		
	1 *	ere reviewed with the			to ensure all potential conce	rns	
		ol Nurse. In June, five			have been		
	residents on the 100 hall were noted to				addressed. <u>EFFECTIVE</u>		
	have urinary trac	ct infections, and in July,			<u>DATE</u> The changes are comp		
	five residents on the 100 hall were listed				and effective by September 2011.	11,	
	on the infection	log as having urinary tract			۷۱۱.		
	infections	<u> </u>					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION  00	(X3) DATE S COMPL 08/12/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR  The Infection Codid not track recululy 2011, she not names kept comi	INTATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Introl Nurse indicated she arrent infections, but for oticed the same resident ing up on the infection	ID PREF	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΈ	(X5) COMPLETION DATE	
	planned on meeting Nursing and the Analysing to put so the infections. So done this in the plant logged the infection agents, but had not tracking why so the infection who is the plant of the plant infection who is the plant infection wh	noticed a lot of hall. She indicated she ing with the Director of Assistant Director of mething together to track he indicated she had not east. She indicated she infections and causative ot been following up and many urinary tract occurring on 100 hall.						
	reviewed on 8/10 Diagnoses included to, Alzheimer's debullous (chronic involving the formurinary retention)  On 8/10/11 at 1:3 observed to proved the proved to proved the prove	led, but were not limited ementia, pemphigus autoimmune skin disease mation of blisters), and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE COMP		
		155322	B. WIN			08/12/2	2011
	PROVIDER OR SUPPLIER		'	6050 S	DDRESS, CITY, STATE, ZIP CODE CR 800 E 92 VAYNE, IN46814	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	including scissor table. RN #1 was gloves without fi The nurse was of resident's buttock saline. The nurse from the overbed cut Xeroform gargauze) without d The nurse then p gauze onto the op buttocks. The nuscissors directly The resident ther movement. The and went a dresseremoved a roll of did not wash her gloves. The nurse of exam gloves whands and proceed paper to wipe the nurse then indicated more supplies. The remove the glove and leave the root hands. The nurse then left the area #1 was then obsermedication cart, if the medication cart, if the m	rved to place her supplies, s, directly on the overbed s observed to put on exam rst washing her hands. Observed to clean the as with gauze and normal expicked up the scissors. It table and used them to uze (petroleum covered isinfecting the scissors. It laced small pieces of the open areas on the resident's urse then placed the onto the overbed table. In began to have a bowel nurse removed the gloves er in the room and if toilet paper. The nurse hands after removing the extended to use the toilet experience to use the toilet experience to est, gather her supplies of without washing her expected to place unding the scissors, into art in the hallway and to get the supplies and enter Resident #43's					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155322			LDING	NSTRUCTION  00	(X3) DATE: COMPL 08/12/2	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  6050 S CR 800 E 92  FORT WAYNE, IN46814					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	place the supplied overbed table. The put on a new pair first washing her cleaned the residuand normal salinuscissors up off of cut the Xeroform the scissors. The small pieces of the pieces of the proceeded the transport of the physician had the proceeded to the physician had the proceeded to the physician had the proceeded to the physician had the phy	was observed to again as directly onto the the nurse was observed to a few of exam gloves without thands. The nurse again ent's buttocks with gauze the the overbed table and a gauze without cleaning nurse then placed the teresident's buttocks. The the treatment and removed the gloves, and to wash her hands. The the treatment and the scissors, from the did take them out of the them into the medication.  The Resident #43 indicated didagnosed Resident tract infections, and had the therapy, on 5/23/11, and 8/1/11.  The Amage of the treatment and the						

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STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155322	B. WIN			08/12/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	<u>.</u>		6050 S	CR 800 E 92		
	SANCE VILLAGE				WAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DETERMET)		DATE
		anal area and toward the					
	1 *	NA #2 was then observed					
		lent's upper inner thighs					
		h cloth, wiping from the					
		ards the perineal area.					
		n observed to use a clean					
		an the catheter tubing,					
	wiping the tubing	g toward the perineal					
	area.						
	CNA #2 was inte	erviewed on 8/11/11 at					
	8:30 a.m. after pr	roviding the care to					
	Resident #43. D	uring the interview, CNA					
	#2 indicated duri	ng the cleaning of a					
		al area, the resident was					
	_	m the perineal area					
		n front to back. CNA #2					
		the catheter tubing was					
		wiping from the meatus					
	downward.	wiping from the meaters					
	downward.						
	The Nurse Practi	tioner (NP) was					
		1/12/11 at 10:45 a.m.					
		view, the NP indicated					
	1	are and perineal care					
	1 ^	ce the risk of Resident					
	#43 getting urina	ry tract infections.					
	A facility policy	titled "Perineal Care "					
	A facility policy titled "Perineal Care," with a revision date of April 2011,						
		_					
		n catheter tubing, staff					
	were to "gently wipe four inches of						
		eatus out" The policy					
	turther indicated	"wipe resident from front					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155322	B. WIN			08/12/2	011
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
DENIAIO				1	CR 800 E 92		
RENAIS	SANCE VILLAGE			FORTV	VAYNE, IN46814		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENC!)		DATE
		center of perineum to					
	1	icy further indicated that					
	· ·	were to "separate labia,					
		a first. Wash between and					
		lownward strokes,					
	_	side to side and moving					
	outward towards	the thighs."					
	The facility Infec	ction Control Nurse was					
	1	/11/11 at 3:45 p.m.					
		view, the Infection					
	_	dicated staff were to					
		re putting gloves on and					
		loves. The Infection					
		rther indicated that					
		as no facility policy					
		eaning of scissors,					
		e cleansed with alcohol					
		prior to using them to cut					
		s. The Infection Control licated staff are expected					
		*					
		ility policy on providing					
	catheter care and	permear care.					
	The Infection Co	ontrol Nurse further					
	indicated that alt						
		ne surveillance of					
	_	hout the facility, she had					
	· ·	oncern with Resident					
		rinary tract infections and					
	1	-					
	frequent use of antibiotics.						
	The facility's DO	N was interviewed on					
	8/12/11 at 2:00 p						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPLE 08/12/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	CR 800 E 92		
RENAIS	SANCE VILLAGE			FORT V	VAYNE, IN46814		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<b>+</b>	,	+	TAG	DEFICIENCE		DATE
	1	ON indicated she was the					
		ity's Quality Assurance (QAA) Committee.					
		view, the DON indicated					
	_	icluded, but was not					
		ty department heads, the					
		r, and the consultant					
		e also indicated the					
		s monthly with the facility					
		ly with the Medical					
	1 *	ON indicated the purpose					
		e was to identify possible					
		to resident care. The					
	DON indicated of	concerns could be brought					
	to the attention of	of the committee by the					
	various departme	ents or by individuals.					
	The DON indica	ted if a concern was					
	identified, the co	ommittee would analyze					
	the problem and	would then initiate an					
	action plan to co	rrect the problem. The					
	DON indicated a	any potential concerns					
		and the use of antibiotics					
		ied by the Infection					
	· ·	who would then bring the					
	issue to the atten	-					
		DON indicated the					
		l Nurse had not brought					
	1 -	ntrol issues to the					
		DON indicated the					
		ot identified Resident					
		JTI's and frequent use of					
	•	washing, or improper					
		hniques as a potential					
	concern.						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	A. BUILDING  B. WING		COMP	(X3) DATE SURVEY  COMPLETED  08/12/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN46814				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMPL		(X5) COMPLETION DATE	
	3.1-52(b)(2)						